REHABILITATION RECORD

SEPTEMBER
AND
OCTOBER
1973

Wheelchair Decor Winners
See page 20

A Case in Point

The following thumb-nail sketch was sent to us by Nathan M. Slater, Ed.D., Director, Rehabilitation Services, Federation of the Handicapped, New York, New York.

The *Rehabilitation Record* will print, from time to time, innovative, different, or unusual placements that underline the possible in cases that seem impossible.

Absence from the labor market for 22 years because of severe multiple disabilities involving osteoarthritis of the neck, spine, and upper extremities in addition to shortening of a leg due to surgery following an arterial blockage, confined this housewife and mother to a wheelchair. Prompted by acute financial need, she sought return to the labor market even if it were to work at home.

At the age of 56 years, having raised two sons and nursed a severely handicapped husband at home, she sought counseling and guidance from the State OVR. High school graduation and earlier employment of fourteen years as a power sewing machine and bookkeeping machine operator did not offer feasible competitive employment outlets because of her physical limitations and prohibitive private transportation costs which would be entailed.

Referred to the Federation of the Handicapped to pursue its Higher Horizons for the Homebound Program which provided daily transportation, Mrs. F. completed a searching vocational evaluation and personal training program wherein she demonstrated solid potential for such clerical work as light typing, record checking, and filing as well as appropriate physical tolerance.

When a large factoring firm sought to hire dependable clerical personnel, Federation of the Handicapped personnel negotiated a private daily transportation arrangement wherein the company agreed to subsidize costs to be modestly shared by Mrs. F. from her earnings as a clerk. Following a two-week tryout, Mrs. F. was engaged as a regular employee when she demonstrated competency of a high order and perfect attendance.

No longer homebound but still using her wheelchair, Mrs. F. has become a wage earner, contributing substantially to the financial needs of her family and a full-fledged member of the labor force, thanks to her own motivation and the joint efforts of employer, State OVR, and Federation of the Handicapped.

REHABILITATION OF CHARACTER DISTURBED ADOLESCENTS THROUGH PRODUCTIVE PARTICIPATION

Eliot D. Chapple, Ph. D.

Sociopaths and psychopaths [1] are hostile, uncooperative, untruthful, exploiters and maneuverers, unmotivated, unreliable and often combative. We have to accept the reality *that is,* namely that psychiatrists do not know how to treat sociopaths and psychopaths; they don't want to treat them; their techniques, even drugs, simply don't work. Although 90 percent of those who would be considered psychiatrically ill are personality and character disorders, the money and medical attention goes to the 10 percent. With rare exceptions, the psychiatrist finds them unmanageable.[2] As a consequence, they are either given labels like delinquent and criminal and relinquished with a sigh of relief to the correctional institutions, or, if they are alcoholic or narcotic addicts, they live in a halfway house of criminality. The alcoholics will be detoxified while incarcerated if picked up by the police or, if narcotics are at issue, they will be "helped" in the latest fashion, by being readdicted to a milder and legal narcotic, methadone, which makes the hunt for heroin more tolerable.

What we have to accept is that we in rehabilitation know, or can know, as much as does the psy-

chiatrist. Given some of the basic concepts and organizational structures of rehabilitation, we are in a far better position to intervene. But what we have to get over is the ambiguity which often paralyzes our efforts. We tend to accept the idea that there is a process called therapy and, after therapy, comes rehabilitation (or habilitation). I hold to the contrary opinion. I believe that therapy and rehabilitation are part of a common process. If you speak of therapy starting, at that very moment, you must also speak of rehabilitation being underway.[3]

Thus we have to enlarge our view of both processes, not in some kind of fashionable framework of social or community psychiatry, which turns out to be largely a means by which the psychiatrist delegates to other professionals or paraprofessionals everything except consultation, and an occasional face-to-face relationship with a patient.[4] To do our job, we have to ask, what is the total network of social interaction of the client; what are his resources and vulnerabilities—easily defined for the character disorders; and how are we going to bring about a level of stable social and vocational adjustment which gives meaning to our goal of habilitation of the person to his ultimate potential? [5]

But this means that we too have to change.[6] We have to become more innovative; we have to alter our ways of doing things. These clients won't put up with waiting; they aren't about to cooperate on the grounds that they need help. They have to be "hooked" first, like being hooked on alcohol or heroin but, in our case, they have to be hooked on *work*.

Their violent reactions stem from being easily disturbed even if, on the surface, they scarcely act so. But even when they are not black or Puerto Rican, they have been turned down a hundred times; a hundred times doors have been slammed in their faces; and they become wild things, trusting no one. Moreover, by the nature of their disorder, they are "loners"; they are unable to adjust to others; they avoid all those except the "patsies" of the world, those whom they can exploit and to whom they give nothing.

We recognize their need for instant gratification (and call it a major difficulty), but what we have to accept and plan for is to utilize this need as the "hook" to get them involved in a vocational setting. We do this in workshop centers which do not need to be sheltered since these people are quite capable of working once they know they will be paid for what they turn out and actually receive that pay at the end of a week.[7]

Our initial focus in the South Bronx Center is to put the adolescents to work.[8] They come in as employees with whatever working papers are required and, if they are not in school, work full time. Those who are in school work before or after; though, in the latter case, State and city restrictions prevent minors from working after 7:00 p.m. They work on a piece rate on subcontracts obtained from manufacturers. The rates are set so that they can make or exceed the minimum wage. In contrast to much of our hospital operation with chronic adult psychotics, there is no need for a sheltered workshop with these young people.

A basic component of our program, sometimes unattainable because of limitations in the type and amount of work available, is to vary job design as a therapeutic tool.[9] Clients may work alone, in small assembly units, or at separate tables in small groups. A variety of possibilities exists which can be used to reinforce certain patterns of interaction or work activity and to inhibit others.

Further, one can and must use the adolescents as specialists—to act as clericals, as supervisors or to carry out materials handling jobs, once again using the jobs within the framework designed for *that* person. At this level—a promotional step—the adolescent is paid on an hourly rate, having previously demonstrated that he can work at the bench. Larger workshops provide many more such opportunities and can thus accelerate the rehabilitation process. Flexible and therapeutic management can be managed within them. Unfortunately, in our Center, we are not yet beyond the small unit organization size because we are experiencing an unacknowledged recession which has reduced the work we receive from many of our contractors.

The qualifying phrase, "unmotivated," by which we characterize our adolescents stems from the long-held belief that sociopathic and psychopathic young people cannot work continuously and consistently. If there are no obstacles between the person and the work, by way of the assorted rituals of evaluation and preparation, they will begin to work immediately, perhaps not sustaining it for long, but willing to come back the next day or even the next hour and try again. Thus we reverse the traditional rehabilita-

---

Dr. Chapple is Principal Research Scientist, Research Center, Rockland State Hospital. This article is based on a paper he delivered before the Delaware Chapter, National Rehabilitation Association, Wilmington, Delaware, January 19, 1972.

tion sequence. Once they receive their first weekly pay, which they are free to spend, the availability of regular work instead of the haphazard and unreliable openings otherwise available gets *them hooked* to work, establishing the habit on a reasonably stable basis. We have found that paying a patient for even a small amount of work leads to longer intervals of time spent working.

In the workshop center in the South Bronx, diagnostic interviews and programed interaction therapy are administered only *after* the person has been working regularly. These are explicitly stated to be the first stage of evaluation of job potential and of training for work in an organization, whether it be in business or in government. Obviously, we have to establish what kind of job would be most satisfying to him, emotionally-interactionally, and we also have to habituate him to organizational performance. He comes to us on referral because his acting out, or violent behavior, has got him into trouble.

Ordinarily, he also acts out, to some degree, in the shop. What he will learn in this training process is how not to overreact, how to learn to distinguish between a variety of interaction patterns, some of which can disturb, others please. He must also learn how to manage his own interaction and adjust more effectively both with his peers and the various superordinate persons who, naturally, or through the way their job is defined, can be severely stressful. All this is learned and practiced as a technique, just as one would learn to hit a golf ball or sail a boat. "Try this," "this is how you do it"—there are no moralistic or interpretative components in the process. That the technique worked, or worked better, or that he was not so disturbed this time, are the criteria of reinforcement for him.

Significant changes in capacity to adjust usually begin by the 3rd month and, for most, are reasonably well established within normal ranges at 6 months; for a few it may take 9 months. Not only are the values of the interaction variables within the treatment course shifted, but they are supplemented by various types of interaction samples taken in the workshop, in recreational activities and the like, to demonstrate a marked drop in acting out behavior. Carry-over is, therefore, an essential part of the evaluation process. As we operate, evaluation is a continuous process from his first coming to work.

In a residential treatment center such as our unit at Rockland when it was in existence, the process can be accelerated.[10] The organization of the total treatment and rehabilitation program can be highly

structured—i.e., within reasonable limits, the interactional environment can be controlled and focused on the young person's problems. In a community center, where the adolescent comes to work, to take part in such center activities as we can provide, and to undergo the retraining (therapy) program exactly like those we used in the hospital, the controls are, naturally, much more limited. Once clients leave the center to return home, to be on the street, or to go to school, existing and available relationships can, and often do, intervene. It is not a mere problem of reentry from a residential center where an organized program of followup (and a center such as ours) can provide stability against stress. The task is more complex; only because vulnerability cannot be treated in a concentrated fashion.

For what we have to deal with, either as reentry or as a kind of splitting off of part of the person's relationships to reestablish new and stable ones in the center, are the problems which the community presents. And though it is customary to talk about community with an implicit assumption as to its organizational coherence, the fact is that this is largely fiction, particularly in the ghettoes of the inner cities.[11]

Community organizations have reality only through interaction. The relationship of people in the various focal points in the networks are likely to be shifting and unstable, constantly at the mercy of varying personality needs and temperamental reactions as adjustments fluctuate between people. This variability is made worse by the constraints which space (crowding and separation), technology, and custom impose on the order in which people must interact through some kind of structured and learned sequencing. It is further differentiated by symbolic ambiguity, which restricts the communication process. These are the cultural dimensions of the anthropologist; in the ghettoes, their influence on rehabilitation can often appear chaotic.[12]

Moreover, though the stereotype of the social scientist (and the activist of our society) has it that there is a power structure, an Establishment, which maintains a tight control underneath all these signs of instability, the fact is that this is only one more instance of the way the logics of our culture (not the science) try to impose order and belief on reality. It is more accurate to recognize the structure as a maze of disparate personalities and relationships, with no unifying center able to establish hegemony over the whole.

So this is the world within which rehabilitation must take place. Beginning with each client, we have to trace out his network of relationships and evaluate their potentialities and obstacles by interactional observation. The simplest method is to record the *who does what, with whom, when, where, how long,* and *how often*. And what we find, commonly, is a series of highly stressful relationships with minimal compensatory interactions to take up the slack, except what we can provide in a workshop center.

So what we must do is to evaluate this network, supplementing the clocking of contacts with micro-interaction measurements of the patterns of adjustment (using a portable recorder) to estimate the magnitude of the stresses imposed by each contact. Paralleling these, as our information grows about the adolescent's own personality and temperament reactions as well as the progress he is making, we can begin to look at the community, not as a generalized entity with a label which, if properly organized in some magical way, could provide stability, but as *his* environment, which will differ from that of every other person.

Granted this may appear to increase the difficulty of bringing about rehabilitation. How much easier it would be to have available some kind of homogenized community prepared along well-proceduralized lines to process the individualities which human beings present! But this is not the case. If it were, it would run counter to the fundamental and recalcitrant biological principle of individualization. It is an individual that has to be habilitated, placed in a situation where *his* adjustment and *his* performance can be maximized. Inevitably, this means accepting the fact that his environment must differ from another's.

So what we are slowly developing is a way of identifying the environmental requirements and facilitating placement in the most habituating setting by utilizing staff and clients to build relationships with potential employers. In an area like the South Bronx, there are no large corporations who, in theory, might be persuaded to take on a few adolescents. This is a process at the mercy of high-level corporate, and thus noncommunity, decision, a highly vulnerable gamble for us not merely to be dismissed as tokenism. Only if the area becomes economically strengthened can we expect to obtain steady employment for our clients in jobs which are open ended with regard to opportunity. The theory that "massive" infusions of capital can develop business enterprise in the ghetto fails primarily because

enormous effort is required to find, train, and hold reliable workers.

Those employed soon find that they do not have the educational achievement levels and opportunity to rise in the ranks which corporate enterprise and civil service require. Moreover, employment, training and supervision tend to be highly ritualized, inappropriate for blacks and Puerto Ricans, even if their problems were not occasionally complicated by not too serious instances of acting out. On the other hand, in the small businesses of the South Bronx and in the various community programs, ability to obtain and hold a few reliable employees is crucial to survival and potential expansion.

For many young people, particularly those not addicted, it seems possible to bring them in and to hold them, since we can deliver to them what we promised—get them to the point where they can adjust successfully on a job and look forward to moving ahead, within the limits which they set for themselves. There are many, however, (and this is particularly true of the addicts) for whom residential treatment, using precisely this form, is essential. This also applies to those others whose home situation is so seriously disturbed that even the workshop center cannot exert a sufficient countervailing force when they themselves are almost continuously acting out.

The present fashion is to decry State hospitals and to praise to the skies the potentials of community mental health centers, rehabilitation centers, outpatient or after-care clinics or whatever. I am certainly not here to defend State hospitals as they are. But the character disorder adolescent, (and adult) can't be brought to attend community centers for something called therapy, unless he is escorted there by the police in a paddy wagon and watched over while there! The bulk of the psychiatrically ill—the dangerous, violent persons who make up most of society's problems—either have to be hospitalized (committed in any case for 3 to 6 months) to reduce the impact of community stresses to a manageable minimum or, hopefully, they have to be brought immediately into the stream of what I have called "productive participation." [13] They have to learn by doing and by being paid therefore. Only then do they come to view the training they get through interaction therapy as basic to getting and holding a good job.

We are too often stymied, legally and professionally, by the American tradition of mixing up the legal stereotypes of the past with what I hope are the rehabilitation processes of the future. It is up to us to demonstrate that there are alternatives to hospitalization or commitment to correctional institutions. We can only do this if we look at the problem, in this case, the violent acting out adolescents, with objective eyes, start where he is at, and avoid trying to mold him into the straitjacket of traditional rehabilitation procedures. To quote from my favorite author, as Mr. Oliver Wendell Holmes used to say, I said in my Dabelstein lecture "With the disadvantaged, we have to abandon our ritual sequence and enable the client to get immediate gratification for effort expended, to build relationships with him as a byproduct of established patterns of positive reinforcement. So far, sheltered workshops appear to be the most flexible way of doing so, for here we can facilitate the growth of productive participation. Those of us trying it have found it a remarkably effective first step in involving and holding the client.

"Evaluation? Well, that comes later. Social adjustment or work training before the client starts to work? First, the work, and success at so doing. On-the-job management of the learning process can be built into the system. And sheltered workshops are by no means the only way of going about it. In Cleveland, the Vocational Guidance and Rehabilitation Services has bought up houses in the ghetto area around the center with clients living on the block rehabilitating them and ownership turned over to one after another by group decision. It is up to us to innovate the models which can be used in different cultural settings." [14,15,16,17]

And what I mean by productive participation, which I have discussed at greater length elsewhere, goes far beyond the conception of work as a "regular" job for pay. Of course, one hopes to be able to make vocational placements, fitted to the personality needs, which minimize stress and debilitating temperamental reactions thereto. But there are other alternatives, if appropriate jobs are not available or the weight of the handicaps is still too great. Within each cultural setting, there are a variety of roles in which what we used to call "chores" are essential. Through these a person can gain acceptance and receive reciprocally continuous reinforcement for his participation.

Think of the time and energy expended by people in a group preparing for ceremonials, festivals—of the many things which have to be done if the life of a group is to realize its full potentialities. Very often the nonjob productive participation in the

activities of family group, neighborhood and community associations (or informal activities) in the church, in fraternal societies, sports organizations (the list is endless) is that for which they live. The job is performed only as the means of support; it makes possible these other involvements.

So what we have to try to do is to identify networks for the adolescents which can counterbalance the forces which, before therapy-rehabilitation, led him to be a loner. We cannot assume that mere job placement is the end of his road; in fact, it is often essential to facilitate productive participation in some sort of group network if he lives at home while he is still at the workshop center. Not merely does his transition to a viable individuality become accelerated; his acceptance and enthusiasm for a life with others is enhanced, once his "place" begins to be defined.

For many of the younger adolescents, jobs per se are almost nonexistent. They must wait for age barriers to be broken down. Waiting can be highly stressful when you have reached the level where placement should occur. By using the resources which the procedures of productive participation reveal, we can give his life meaning within the world to which he is to return, without assuming that this cannot begin until he is old enough to find a "job," after which rehabilitative responsibilities are supposed to be ended. This belief is a myth, but it need not be one if his adjustment be looked at as a whole way of living, and not limited to the vocational context.

Notes and References

(1) What I have to say about the violent acting-out adolescents applies both to younger and older people of this condition. It applies to young adults who have little but chronological age to distinguish them. Depending on terminology, they can be categorized as having personality or character disorders or as being sociopaths or psychopaths. Not included here is what is often called the dyssocial sociopath since these people achieve reasonably good social adjustment within their groups, typically the street gangs. Their violence comes in the way the gang relates to other gangs, over "turf" or girls, i.e., property.

(2) Thompson, George N. "Perspectives in Biological Psychiatry," (paper presented at Annual Meeting of The Society of Biological Psychiatry, San Francisco, 1970).

(3) Chapple, E. D. *Rehabilitation: Dynamic of Change,* Ithaca, N.Y.: Center for Research in Education, Cornell University, 1970.

(4) Panzetta, Anthony F. *Community Mental Health: Myth and Reality,* Philadelphia: Lea and Febiger, 1971.

(5) Chapple, E. D. See reference 3.

(6) ———, "Does Rehabilitation Have a Future?", Dabelstein Memorial Lecture, National Rehabilitation Association, Chicago, 1971 (submitted for publication).

(7) ———, See reference 3.

(8) The work described here has been supported in a large part by SRS (15–P–55055/2—"Workshop Community Center for Unmotivated Adolescents"; RD–2490–G "Treatment of Adolescent Primary Behavior Disorders"; and RD–2298–P—"Programed Placement for Nonpsychotic Disturbed Adolescents") and National Institute of Mental Health grant 5–R20–MH–15166.

(9) Chapple, E. D. See reference 6.

(10) Lubow, Bart K. "Work-flow Influences on the Interaction of Schizophrenics," *Arch. Gen. Psychiat.,* 25, 155–60, 1971.

(11) Chapple, E. D. and Esser, A. "Workshops in State Hospitals," *Psychiat. Quart., Suppl.,* 38(2): 317–22, 1964.

(12) ———, *The Adolescent Sociopath,* (to be published).

(13) Panzetta, Anthony F. See reference 4.

(14) Chapple, E. D. *Culture and Biological Man,* New York: Holt, Rinehart and Winston, 1970.

(15) ———, See reference 3.

(16) ———, "Work or Productive Participation," *Rehabilitation Record,* 1972.

(17) ———, See reference 6.

Hearing The Difference

The following is excerpted from a lecture given by Professor A. R. Bodenheimer at the Hadassah Audiology Center, Jerusalem. The lecture was printed in *Demama,* the Journal of the Association of the Deaf and Mute in Israel.

There is a very simple, even primitive fact connected with deafness, that makes deafness different from other kinds of handicaps. It is a very elementary, primary, trivial difference—yet a most important one. It is that *deafness cannot be seen* (unlike defects of limbs, blindness or other impediments). . . . Socially speaking, *deafness is heard.* In plain, you do not see deafness, you do not feel it—you hear deafness. It is heard by another person unprepared for it. You sit in the bus and ask the person next to you, "What is the time, please?" You get the strangest, unexpected answer. The impact on the questioner results in a specific form of stupefaction connected with deafness, and one of its most dramatic, if not the very most dramatic in quality.

This is, by the way, one of the reasons why I *recommend a visible hearing-aid.*

It serves two purposes:

(1) *It prevents stupefaction* of the partner in conversation, who with the help of the indicator is prepared for whatever may result.

(2) It helps the deaf person *to get at and to preserve his identity.*

Do not therefore just think of the hearing-aid as an audiological *element,* but as a *physiognomic* one too.

Family Rehabilitation In Process

Louis Y. Nau, Ph. D.

Arizona Job College graduation day for the Luciano Alvarez family. Mr. Alvarez was trained in automotive body and fender repair. He is now working in Casa Grande, Arizona.

"The integrity of a society rests with the integrity of family life."
—Margaret Mead

Many sociologists and social anthropologists hold that the family, as a basic social unit, serves as a primary change agent in society. Many rehabilitationists, educators, and manpower developers have been slow in putting this tenet into practice. Yet, the desire to bring about more significant and durable change in people through traditional vocational rehabilitation, education, and manpower training has spurred the search for new and more successful service delivery methods.

The comprehensive total family rehabilitation process is providing effective and lasting change for severely disabled, disadvantaged and multiproblem families. The process, however, is no "Waldenian dream" or "Utopian panacea." It is a functional and adaptable human service approach which is experiencing success in a number of centers around the country. The process offers service delivery alternatives for heretofore "impossible" cases.

Dr. Nau is Special Assistant to the Commissioner, RSA.

Method

There are two general types of family oriented programs, residential and nonresidential. Although the desired results are the same, both approaches are different in application.

The residential method affords tighter case control, greater structure and coordination of program elements, development of a "sense of community" or "esprit de corps," and an environment relatively free from outside distractions and interference.

Nonresidential programs, on the other hand, encourage greater family initiative, cost less to operate, call for more external community organization and integration, and reduce problems involved with relocation of families after graduation.

The term, family *rehabilitation,* as used in this article, includes four different program orientations. They are:

- *Rehabilitation,* which approaches case service from a physical or mental disability, behavioral disorder or disabled disadvantaged point of view, using established vocational rehabilitation processes such as rehabilitation counselor case management evaluation, individual plans, supporting services, etc., as the basic service components upon which is built the comprehensive service system necessary to provide and facilitate total family change.
- *Manpower,* which emphasizes the fullest development and utilization of human resources for participation in the labor market of competitive society. Traditional employment service manpower training approaches are used as the catalyst for the more extensive and intensive service components.
- *Vocational education,* which uses a career education model and vocational training rationale to organize a complex of theoretical and practical human service elements into a family program.
- *Employment assistance,* which encourages the maximum development of employment skills and centers the total family program activities around job placement and retention, with other supportive family services bolstering the basic goal.

The variations between these orientations is small and consequently will be considered as a single ap-

proach for purposes of this article. The differences between residential and nonresidential methods are not as small and will not be treated as one.

The process of family rehabilitation, then, will be explained in terms of the family concept, variation in project models, common characteristics of family rehabilitation, and projections for the future.

Family Concept

Why *family* rehabilitation? What are the advantages of this over other human services approaches?

If one accepts that disability, poverty, or other kinds of social, educational or cultural deprivation do not exist in isolation, and always adversely affect other family members, as well as the family unit as a whole,[1] the need for and the advantage of family-centered human service programs is easy to understand.

The intrafamily response to *pain* (any type of physical, mental or social trauma) can only be measured by its cumulative adverse effect upon each member of the family. The rehabilitation or change process needed to overcome the effects of family pain must be totally family oriented and must be individually, yet cumulatively, administered. Thus, family rehabilitation is a natural process, delivered in a natural setting to deal with and correct unnatural or abnormal conditions.

Poverty programs conducted since the early 1960's attempted to break the poverty cycle by only providing skill training and jobs for a primary wage earner. Subsequent data from these programs revealed high recidivism rates, increased welfarism, and growing social discontent.

Family-oriented programs have been more successful,[2, 3] for although one individual in a family might fail, every other family member from primary bread winner to smallest child has been given both the training and the opportunity to develop and succeed. The family model is offering hope that a poverty cycle can be broken, that dependency on welfarism and handicaps resulting from disability can be greatly reduced through this unique process.

Project Models

There are eight residential total-family projects currently in operation in this country. As previously stated, they represent four different emphases. One is a rehabilitation model, two are manpower-oriented programs, another is concerned with vocational education, and the other four are employment assistance and relocation projects.

Arizona Job Colleges, Inc. (*AJC*), Casa Grande, Arizona, has been identified as the most mature, comprehensive, versatile, and publicized of all family projects.[4, 5, 6, 7, 8, 9] As a rehabilitation model, traditional vocational rehabilitation services are blended with family living skills, parent-child development, public school and community activity participation, home health and safety training, vocational and skill training for all family members of working age, recreational instruction, adult basic education with special emphasis in English-as-a-second-language, personal grooming, budget and finance, home management, and many other related learning activities.

As a special emphasis, the AJC staff began, from the outset, to establish strong working relationships with business and industry in the project area.[10] This effort has paid off in better placement and employment opportunities.[11]

A "mini" or "community prototype" government has been established to assure family client access and participation in the administration, conduct, and activities of the project. Furthermore, the project staff strives intentionally and continually to involve family members in every possible decision-making and learning process which can affect the family during their 1-year participation.

The project, now in its 3rd year, is multifunded from HUD, OEO, RSA, HSMHA, and various Arizona State agencies. Other broad-based funding has been provided by the Ford Foundation, which was largely responsible for the development and general support of the project since 1968.

Facilities include 80 residences, a multipurpose community building containing classrooms, a 180 child capacity parent/child development center, a teen center, a library, counseling and guidance offices, a cafeteria, and an amphitheatre. Other facilities are 25 mobile units adapted and designed as a medical facility, administrative offices, and classrooms.

The project has a rural emphasis, working with migrants and handicapped rural families. The cross cultural client population (55 percent Chicano, 19 percent Indian, 17 percent white, 9 percent black) is a unique feature at AJC and has proven to be a strong factor in developing project strength.

Choanoke Area Development Association (*CADA*), Rich Square, North Carolina,[12, 13] and *Manpower Education and Training, Inc.* (*MET*), Cleveland, Texas.[14] The Office of Economic Opportunity has funded and sponsored these two family manpower models which are directed at the employment and living problems of migrant farm workers. Although the program components are similar to and nearly as comprehensive as those at AJC, there are some basic differences which should be noted.

CADA conducts a 6-month pre-vocational training period prior to project acceptance. This process serves as a feeder and screening mechanism for recruiting families whose motivation, capabilities, and interests have been measured prior to the 5 to 10 month (6 months average) on-site training. This has

proven to be a successful variation, reducing both the dropout rate and ultimate project cost per client family.

MET is a short term, family-involvement project with strong emphasis on adult education, manpower training, job placement, and followup. Average stay is 90 days. In contrast to AJC and CADA, the level of family living, counseling, community involvement, etc., although intensive during the 3-months participation, is felt by some to be too short to facilitate indepth or lasting change in family patterns and life styles. The shorter involvement makes the intensive service package available to greater numbers. This is a distinct advantage from a cost/benefit point of view.

Mountain-Plains Education & Economic Development Program, Inc. (MPEEDP), Glasgow, Montana, is the principal exemplary demonstration in vocational education, sponsored by the Office of Education, DHEW. Of the projects included in this article, MPEEDP is the most elaborate and sophisticated. Operating under a 6-State regional Board of Directors, it accommodates some 200 families, with additional facilities for solo parent families and singles.

A broad range of career education classes are arranged in vocational clusters. This offers specific, yet extensive, skill training opportunities. The day care center, home living and home management courses, counseling, recreation, remedial education, and onsite public school program contribute to a full year of well-rounded academic and practical education.

Recruits come from the six participating States. Graduating families return to the town or city from which they came, where housing, job placement, and followup are provided by project staff.

After more than a year of operation, MPEEDP is now entering a full-blown research phase under the direction of the National Institute of Education which will offer much detail to the developing "state of the art" of family rehabilitation.

Bureau of Indian Affairs. BIA is the true pioneer in family rehabilitation even though its efforts have not been labeled as such. Through its Employment Assistance centers, located in Madera and San Diego, California, Roswell, New Mexico, and Fort Lincoln, North Dakota, comprehensive residential services have been offered for many years to seriously deprived and handicapped Indians. They are set up for both total and solo parent families and singles.

Project officials, as well as independent monitors, have noted the high degree of success, participation, and learning of the Indian families who have moved to the projects for assistance. With emphasis placed on vocational education and training, remedial education, and other family life skills, "graduates" have been able to obtain and keep good, in fact, better-than-average jobs.

Studies, however, have shown that many families have quit their jobs and returned to reservation living shortly after relocation in industrial or urban centers. Relocation and separation from the extended family was not acceptable and served as cause to return to the reservation.

The BIA projects have served a useful purpose, nonetheless, for many Indian families are now enjoying significant success and satisfaction in life as a result of their residential total-family rehabilitation experience.

Common Characteristics

These eight projects were developed virtually without any knowledge or data concerning other such programs. It is amazing that so much similarity exists!

Individual and Family Plans. Following acceptance, move-in, and orientation, family members participate in a thorough process of individual and family evaluation. On the basis of these findings, personal and career development and rehabilitation plans are agreed upon. A master rehabilitation plan, designed jointly by family and counselor, is set up for the whole family. Goals and objectives which are attainable, are set to meet the needs and reasonable aspirations of the family.

Eligibility Criteria.—Each project has unique eligibility criteria. Generally, however, they include a low income factor, poor work history, physical or mental disability (where applicable), total family participation, agreement to live on the project site, clear indication of motivation to change, character references, and legal marriage.

Perhaps the most important element in determining eligibility is the family commitment to program participation. In some projects, client families sit on the entrance screening committees to review the qualifications, commitment, and motivation factor of prospective families.

Community Involvement. — In every project, a sense of "new community" is developed. In several, special effort is made to develop local community participation. Attendance, involvement, and membership in civic and service organizations, local government, public school programs, and PTA are encouraged and fostered. Such activities tend to develop reciprocal feelings of belonging and acceptance on the part of both client families and local citizens.

Job Skills for All.—The two-income family has been in vogue and growing since the early 1940's. Many disabled and disadvantaged families, however, have not had the training or opportunity for more than one wage earner. Family rehabilitation projects generally provide any or every family member of wage earning age a chance to receive at least basic employment skill training. Second family incomes have become "the way out" for many graduating families.

Cost Effectiveness. — Operating costs range from $1,200 to $2,200

At AJC even recreation can be instructional. Here Pitt Adams learns leatherwork.

per person, per year. These figures appear, on the surface, to be far from austere or cost beneficial. However, data now being amassed are proving that the basic costs are being far offset by the subsequent earnings of families and savings to society. Early findings from research conducted at AJC [15] show that one year after graduation, 105 families which had median annual family earnings of $2,616 were making an average of $9,069 per year, a significant increase. Comparable data are also present from other projects.

Variations and Implications

Throughout this article, a variety of approaches to family services has been discussed. This versatility is perhaps the greatest strength of the family rehabilitation concept.

Even though the majority of projects currently in operation are located in rural areas, project officials are in general agreement that the concept, with only minor changes, will work in urban areas.

A service integration project, sponsored by the SRS in Anacostia, Maryland, is a comprehensive family project. In its developmental stage, AJC served as a model for service delivery components and processes. This *nonresidential,* family project is a good example of adaptation inherent in the family approach.

Even traditional vocational rehabilitation has been able to utilize a modified family model efficiently. Arizona's Department of Economic Security, with a grant from RSA, is developing specific service integration programs for the vocational rehabilitation of public assistance recipients through the family rehabilitation capability at AJC. In this model, the VR counselor can utilize the fullest variety of rehabilitation services to provide the maximum opportunity for change and rehabilitation to each member of a welfare recipient family.

The Future

Having been significantly involved in the planning and implementation of one of the projects mentioned in this article, having visited, monitored, consulted with, or thoroughly studied all the programs discussed here, I have great confidence in and expectations for the future of family rehabilitation.

There is an important place for family rehabilitation centers and projects in this country. This does not mean that it is necessary or desirable for every case of disability, poverty, disadvantagement or social trauma. However, for multiproblem families, for the chronically poor, for the habitually under- or unemployed, and in the case of prolonged or severe disability,[16] family rehabilitation is perhaps the only method which holds true promise of successful resolution to the problem.

I would, therefore, recommend the establishment of at least one comprehensive residential, total family rehabilitation center in each federal region to accommodate and facilitate the reentry of eligible families into productive employment and satisfying participation in society. I further recommend the establishment of nonresidential centers in all major population centers to treat problems where change can and should take place, in the family, where things happen.

References

(1) Nau, Louis Y. "Why Not Family Rehabilitation?" *Journal of Rehabilitation.* National Rehabilitation Association, Washington, D.C. May–June 1973, p. 14.

(2) Franklin, David S. *Changing Families in a Changing Society: An Administrative Field Report.* Los Angeles, California: University of Southern California. Nov. 1972.

(3) White, Jack. *A Comparison Analysis of Total Family Residential Training Centers.* Washington, D.C.: Educational Systems Corp. Nov. 1972.

(4) Cook, James E. "Stopping the Clock for the Poor." *Arizona Magazine.* Phoenix, Arizona: Arizona Republic, 1972.

(5) Manning, Diane. *Case Study—Family Rehabilitation.* Washington, D.C.: Manpower Information Service. Sept. 1972.

(6) Murphy, Betty. "Arizona Job Colleges: Defeating the Dependency Syndrome." *Opportunity Magazine.* Washington, D.C.: Office of Economic Opportunity, U.S. Government Printing Office, June 1972.

(7) Panitch, Mark."Arizona Job Colleges Pioneer New Poverty War Approach." *Arizona Daily Star.* Tucson, Arizona. Aug. 1, 1971.

(8) Udall, Hon. Morris K. "Retraining Whole Families Breaks Poverty Cycle." *Congressional Record.* Washington, D.C.: U.S. Government Printing Office. Aug. 5, 1971.

(9) Bartholomew, Richard J. "Breaking the Poverty Cycle." *County Manpower Report.* National Association of Counties: Washington, D.C. Vol. 2, No. 2, Apr. 1973.

(10) Merkel, Richard L. and Bartholomew, Richard J. "A New Coalition? The Businessman and the Poor." *Arizona Business Bulletin.* Arizona State University, Tempe, Arizona. Jan. 1970.

(11) Glasso, Myfanway. *Arizona Job Colleges, Inc.—First Year Evaluation, Final Report.* La Jolla, California: Systems, Science and Software, P.O. Box 1620. 1971.

(12) White. *Op. Cit.*

(13) Lubin, Shami. "Seasonal Farmworkers Triumph Over Technology." *Opportunity Magazine.* Office of Economic Opportunity. Washington, D.C. U.S. Government Printing Office. Feb. 1972.

(14) White. *Op. Cit.*

(15) Glasso. *Op. Cit.*

(16) Shellhase, Leslie J. and Shellhase, Fern E. "Role of the Family in Rehabilitation,"*Social Casework.* Family Service Association of America, New York, N.Y. Nov. 1972.

Retarded Attendants for the Handicapped

Robert M. Urie, Ph. D. and Donn Brolin, Ph. D.

The purpose of this paper is to examine the perennial problem of attendant care for quadriplegics and to propose a possible solution to that problem. Physicians, nurses, rehabilitation workers, placement counselors, social workers, as well as family and friends of the severely handicapped, are all acutely aware of the need for attendants.[1, 2, 3, 4]

Most workers are familiar with the problem of locating an attendant for the severely handicapped person who is ready to live in a relatively normal setting instead of a hospital, rehabilitation center, or nursing home.

While attendant services are typically available from orderlies, aides, and other paraprofessionals in medical and medically-related facilities, such services are only part of an expensive system which goes beyond the usual daily needs of a rehabilitated quadriplegic. Under these conditions, the quadriplegic pays a high daily rate for the total system of services, of which attendant care is the only essential element.

The term "quadriplegic" is inadequate as a means of describing people or their physical condition. As a term, it simply indicates loss of function in all four limbs, but it does not indicate the extent of that loss. Frequently, it is used to suggest almost total paralysis of all four limbs, especially in the legs and hands, but with some arm movement remaining. In other instances, it may refer to a generalized weakness in all four limbs rather than total paralysis. Thus, one quadriplegic may be able to move only his head, while another may even walk. Again, two quadriplegics may have essentially the same results on a standardized muscle evaluation, but by virtue of motivation, training, body weight, and other factors, one handles his personal care independently while the other requires total nursing care.

We arbitrarily use the term "quadriplegic" here for that person who does require direct, personal physical assistance with his activities of daily living. We intend that the concept be interpreted quite broadly and, therefore, be applied to as wide a range of disability groups as appropriate. It applies to anyone whose daily routines are profoundly restricted to the convenience or control of his attendant. The attendant becomes, in fact, the quadriplegic's key to survival.

The Quad's Routines

There are several critical routines for the quadriplegic which require attendant care. When he first awakes, the attendant must help him transfer to his wheelchair. Hydraulic lifting equipment greatly reduces the physical strain on an attendant when the handicapped person is large and heavy. For small or medium-sized people, the lift is unnecessary. But the fact remains that an attendant is essential from the very first hour in the quadriplegic's day.

Whether or not the handicapped person uses a bedpan or transfers to a toilet seat, the attendant is required on a routine basis. Assistance is also required for catheter preparation and irrigation. Many quadriplegics are unable to handle these routines due to nearly total loss of hand and finger function.

Dr. Brolin is Associate Professor, Department of Counseling and Personnel Services, College of Education, University of Missouri-Columbia; Dr. Urie is Director, Health and Rehabilitation Services, St. Andrews Presbyterian College, Laurinburg, North Carolina.

Having completed all bathroom routines with attendant assistance—including shaving, bath or shower, fixing hair, and brushing teeth—the final personal care routine for the morning is dressing. This typically includes reaching for clothes in closets in addition to actual dressing.

When an electric-drive wheelchair is used in an architecturally barrier-free environment, the quadriplegic is essentially independent for many hours per day. The attendant assists with meals, serving and cutting meats, attaches splints or other devices, and generally supervises the activities. The attendant may also be required to give bathroom assistance one or more times during the day. Nevertheless, there are several consecutive hours of relative independence for the quadriplegic, in the proper circumstances.

At night, the personal care routines are repeated as the quadriplegic prepares for sleep. In many cases, the attendant is still "on duty," however, getting up during the night to turn the quadriplegic from one side to the other in order to avoid pressure sores.

Some Considerations

Parents who have cared for their handicapped child over a period of several years or from birth do not, of course, see themselves as attendants. Their routines are so habitual and well developed that they are scarcely conscious of the actual work involved. It is only when the handicapped child is facing a new living situation, or when age forces physical limitations on the parents, that there is any real awareness of the problem.

For the adult quadriplegic, the same existential level of awareness occurs when he attempts to leave the hospital or rehabilitation setting. Then he is faced with the very difficult challenge of locating an attendant who can meet his physical care needs.

While we have addressed ourselves primarily to personal physical care needs, it is assumed that an attendant will frequently be engaged in additional duties such as household chores, shopping, and running errands. This additional area deserves further investigation. It might be more desirable to maintain a clear distinction between attendant roles and maid roles. Such a distinction would tend to reduce the risk of an attendant "being taken advantage of." The attendant should not attempt to meet the quadriplegic's every need or to be his primary social contact. These relationships should normally be established under supervision by a professional counselor or caseworker who could provide ongoing supervision for an extended period of time.

There are many problems with social relationships in the quadriplegic and attendant roles. There are also many possible solutions to these problems. It is beyond the intended scope of this paper to resolve those important issues. We do not know, for example, if group living, or a cadre of attendants, or other types of social arrangements would be more beneficial to all parties. We tend to believe that each relationship is a highly individual matter which will require great patience, understanding, and perseverance in the quest for mutually satisfying lifestyles.

Attendant Qualities

The attendant must be in good physical health with at least average strength and coordination. Psychologically, he must be completely dependable and consistent in routine tasks, with a high degree of patience. He must understand simple instructions but not necessarily remember them from day to day. He should also be able to use a telephone or otherwise be capable of securing emergency medical care.

On the other hand, the attendant does not need to understand medicine or even the reasons underlying basic nursing practice. He does not have to read or write. He does not need to be a superior physical specimen. His instructions come directly from the one who knows best what is needed—namely, the one being assisted. The basic requirement is that the attendant is available, healthy, willing, and patient in routine tasks.

The MR As Attendant

In view of this brief analysis of the attendant needs of the quadriplegic, we suggest that many mildly mentally retarded adults could satisfactorily perform the duties of such an attendant.

Mentally retarded people have been subjected to many misconceptions about their personality characteristics. They have been characterized as peculiar, dangerous, impulsive, aggressive, untrustworthy, delinquent, and unable to learn, just to name a few. While some may develop these behaviors none of these characteristics can be considered symptomatic of the retarded.

There are also many misconceptions about learning characteristics. Many retarded persons do have a generally low expectancy of success when entering a new situation; however, studies of the learning characteristics of the retarded have indicated that they are capable of learning more than we think, but often they initially perform poorly. Many people feel the retarded have a limited capacity to learn based on

their IQ score; yet research indicates that the ability to learn cannot necessarily be correlated with the ability we call intelligence and, thus, it is not an adequate predictor of the learning ability of the retarded.

The physical characteristics of the mentally retarded also vary, depending on the individual. Since most mildly and borderline retarded persons are not actually organically damaged, their overall general health and physical capacities are generally adequate.

Educationally, the mentally retarded often do not receive enough emphasis on socioоccupational competence. Their school programs have tended to emphasize academic subjects. Thus, as pointed out by Kokaska,[5] many retarded are employed in service occupations resulting in limited financial remuneration and, hence, a very marginal status. There is still a tendency to place the retarded in routine repetitive, simple, and low-paying jobs when many could work successfully in more highly paid and challenging occupations.

If given the proper assistance, estimates place the number between 75 and 85 percent of the mentally retarded who could adjust satisfactorily to society.

A review of the literature (e.g., Olshansky,[8] Katz,[9] Wolfensberger,[10] DiMichael,[11] Fenton and Thompson,[12] Bernstein,[13] and Peterson and Jones [14]) reveals that retarded persons could achieve higher levels of personal, social, and vocational functioning if they had better education, training, and vocational opportunities. Studies such as those of Fenton and Thompson [6] on New York State's civil service system and Osward [7] on the U.S. Civil Service have clearly indicated that the retarded have potentials for doing a wide array of challenging, competitive jobs. Brolin's [15] study found that too many retarded persons continue to fail because of the lack of public understanding, appropriate education, housing, evaluation and training programs, parent counseling, and followup.

Most studies that have been designed to ascertain why the retarded have succeeded or failed on their jobs have focused on the characteristics of the retardate. However, recent attention has been directed on external factors like the client's family and community, and agency variables. It has often been pointed out that it is not generally the inability of work skills that hinders the retardate in adjusting satisfactorily in society; rather it is the lack of social skills and/or the inability to take care of all the necessary activities of daily living (e.g., purchasing, budgeting, cooking, etc.).

Recommendations

State vocational rehabilitation agencies, rehabilitation centers and facilities, and other such agencies are serving great numbers of difficult-to-rehabilitate people such as the severely physically handicapped and the mentally retarded. In light of the factors discussed above, it would seem that a mutually beneficial relationship between the two types of handicapping conditions could result. With the current thrust toward career and vocational education in our schools, specific training could be designed to prepare retarded students to work in this area.

In exchange for physical assistance rendered, the mentally retarded attendant would receive a modest income, a home, and a meaningful human relationship with some one who truly needed him. The attendant's need for supervision and social structure would be at least partially met within the role itself. In exchange, the quadriplegic obtains the physical assistance which he requires and, as a result, the psychological security as well.

We highly recommend that the many agencies currently involved in serving the needs of these people begin immediately to develop the methodology whereby some qualified retarded persons will be considered as attendants for those quadriplegics who need them.

References

(1) Urie, R. "Student aides for handicapped college students." *Rehabilitation Record,* May and June 1967.

(2) Urie, R. (Project Director) *Final report, the use of student aides to the physically handicapped in higher education.* Laurinburg, N.C., St. Andrews Presbyterian College, 1971.

(3) Urie, R. and Smith, A. "The effects of peer contact on attitudes toward disabled college students." *Journal of Applied Rehabilitation Counseling,* Winter, 1970–71.

(4) Urie, R. "Can small colleges serve handicapped students?" *North Carolina Personnel and Guidance Journal,* Vol. II, No. 1, November 1971.

(5) Kokaska, C. "The need for economic security for the mentally retarded." In Brolin, D., and Thomas, B. (eds.) *Preparing teachers of secondary level educable mentally retarded: Proposal for a new model.* Menomonie, Wisc: Stout State University, 1971, 18–21.

(6) Fenton, J., and Thompson, M. M. "The process of organizing a program for the employment of the mentally retarded in a state civil service system." *Rehabilitation Literature,* 1967, 282–9.

(7) Osward, H. *A national followup study of mental retardates employed by the Federal Government.* Grant, RD–2425–6, Washington: Vocational Rehabilitation Administration 1968.

(8) Olshansky, S. "An examination of some assumptions in the vocational rehabilitation of the mentally retarded." *Mental Retardation,* 1969, 7, 51–53.

(9) Katz, E. *The retarded adult in the community.* Springfield, Ill.: Charles C Thomas, 1968.

(10) Wolfensberger, W. "Vocational preparation and occupation." In A. A. Baumeister (ed.), *Mental Retardation,* Chicago: Aldine, 1967, 232–273.

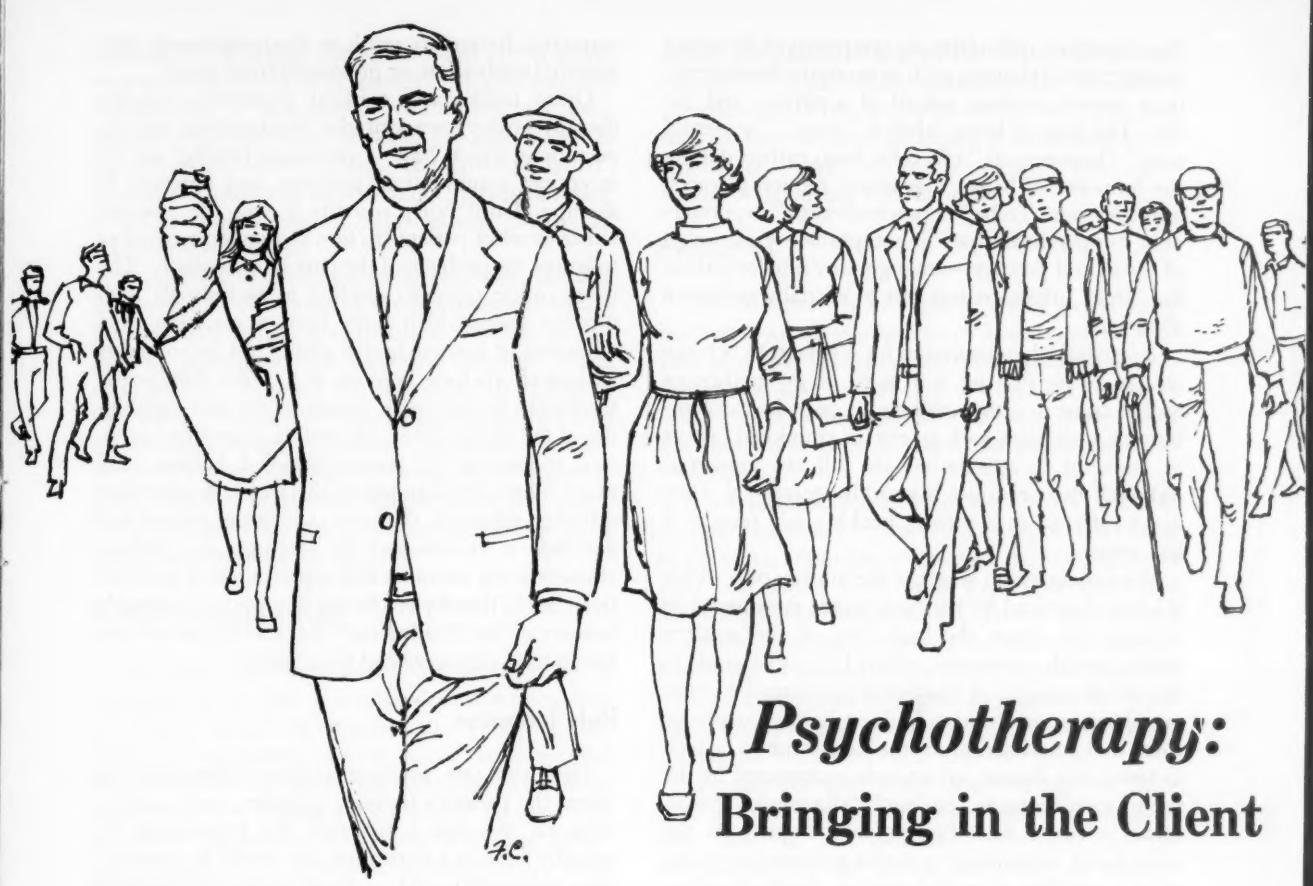
(11) DiMichael, S. G. "Are jobs for the retarded increasing?" *Mental Retardation,* 1967, 5, 40–41.

(12) Fenton and Thompson, *Op. Cit.*

(13) Bernstein, J. "Mental Retardation: New prospects for employment." *Journal of Rehabilitation,* 1966, 32, 16–17, 35–37.

(14) Peterson, R., and Jones, E. M. *Guide to jobs for the mentally retarded.* Pittsburgh: American Institute for Research, 1964.

(15) Brolin, D. E., "Value of rehabilitation services and correlates of vocational success with the mentally retarded." *American Journal of Neural Deficiency,* 1972, 76, 6, 644–651.



Psychotherapy: Bringing in the Client

Hans H. Strupp, Ph. D., and Anne L. Bloxom

Of the large number of emotionally troubled persons who are referred for help to outpatient clinics, community mental health centers, or similar agencies, only a very small percentage receives psychotherapy for any substantial period of time. A large proportion of applicants never gets to see a therapist, and the relatively few who do frequently stay for only a few sessions. The problem involves selection on the part of the potential patient as well as of the clinic.

Dr. Strupp is Professor of Psychology and Director of Clinical Psychology Training, Department of Psychology, Vanderbilt University. Mrs. Bloxom is his research associate. *This paper is based on the final report of an SRS-supported Research and Training Grant.*

The reasons for rejecting an offer of psychotherapy are difficult to assess: Some people obviously are not serious about entering psychotherapy; some have erroneous notions about it and reject it when they become aware of the need for their active participation; some become discouraged by the reception accorded them by the agency to which they apply; some find the prospect of self-examination extremely threatening; for others coming regularly to a clinic entails too many sacrifices.

The wish to view unhappiness and emotional suffering as a physical ailment is widespread. Since there is no stigma attached to consulting a physician, people most readily turn for help to a general practitioner or internist. They find the pronouncement that they are suffering from a vitamin deficiency, an allergy, or even a heart condition easier to accept

than that their difficulties are symptoms of disturbed interpersonal relations, such as excessive dependency on a spouse, seething hatred of a parent, and the like. The fear of being labeled "crazy," "a mental case," "homosexual," etc. is far from extinct despite the influence of books, magazines, motion pictures, and television. To be "in psychotherapy" or, preferably, "in psychoanalysis" is acceptable—even a sign of status and prestige—among many intellectuals in the larger urban centers but is virtually unknown elsewhere.

It is relatively uncommon for a person to become clearly aware that he is in need of psychotherapy and to come to a therapist on his own. In the community, physicians with an eye for emotional factors in illness or incapacitation are still not numerous although their number is steadily increasing. They make referrals to a mental health clinic only as a last resort.

We may question whether the information which is being dispensed by the mass media is as useful as it might be. Since the beginning of the modern mental health movement, efforts have been made to remove the stigma of emotional problems by defining them as an "illness." [1] It is hardly surprising then, that emotional problems have come to be seen in terms of a disease, an attitude encouraged by the use of such terms as "patient," "diagnosis," "treatment," "cure," etc. The psychotherapist, on the other hand, attempts to make his patients see neurosis as a problem of maladaptation, faulty learning, and the like. The patient comes to realize that he is not the victim of a disease visited upon him by mysterious forces and that he must take an active part in his own treatment. Only in recent years has neurosis come to be viewed as a problem in living and adaptation; consequently, psychotherapy is not a technique for "treating" or "curing" a patient but rather for increasing his ability to cope more adequately with the everyday problems in living.

Very few people, even highly educated ones, have a clear understanding of the process and goals of psychotherapy, the role the patient is expected to play, and the kinds of expectations he might reasonably entertain. In addition to sheer lack of information, prospective patients have unrealistic expectations and fantasies about the psychotherapist and his "magic"; they are afraid of the unknown; and they have an understandable skepticism about the utility of "mere talk" as a cure for anything.

It is small wonder that the foregoing factors complicate the patient-therapist relationship and, unless corrected, frequently result in disappointment, premature termination, or prolonged frustration.

Quite unlike any medical treatment, psychotherapy presupposes attitudes, motivations, and expectations which have a profound bearing on the inception, continuation, progress, and outcome of therapy. Until fairly recently it was the practice either to select patients to fit a particular method or to ignore the problem of the patient's suitability. The latter course typically resulted in exceedingly high dropout rates which have been a common phenomenon at mental health clinics. In recent years various efforts have been made to tailor therapeutic services to fit the needs, expectations, and capabilities of the client. Crisis call centers, store-front agencies, indigenous or paraprofessional helpers, and many others are examples of this trend. A somewhat different approach, the one to which this project was devoted, is represented by attempts to produce changes in the attitudes and expectations of prospective clients, thereby rendering them more amenable to more or less "traditional" therapeutic procedures which have demonstrated their utility.[2]

Role Induction

How can one produce a better alignment between the patient's feelings, attitudes, and expectations on the one hand and the experiences he actually faces as a patient on the other? A commonsense approach would be simply to inform him what psychotherapy is about and what it is like to be a patient. The object here is to induct the person into the patient role or to provide him with "anticipatory socialization for psychotherapy." [3] To accomplish this goal one might expose the patient to a role induction interview (RII) prior to psychotherapy in which the patient is told what he needs to know. Such an interview might be conducted either by the therapist himself [4] or by another trained person.[5] Another approach consists of vicarious therapy pretraining, in which prospective patients listen to a tape recording illustrating "good" patient behavior in group therapy prior to the beginning of actual group therapy.[6] More recently, Truax has employed videotapes for the same purpose.

Does a role induction interview have a favorable effect on the course and outcome of psychotherapy with clinic patients? A study conducted at the Johns Hopkins Hospital [7] found that their experimental group, which had been administered the RII, exhibited better in-therapy behavior; it had a better

attendance rate; and therapists rated group members more favorably with respect to establishing and maintaining a therapeutic relationship. Of even greater importance are the better outcome measures for the experimental group. The latter included: Therapist's rating of improvement; patient's rating of mean target symptom improvement; and social effectiveness ratings.

In addition to producing better outcomes, the RII gave evidence of increasing the interpersonal attraction between patient and therapist which is an important prerequisite for successful therapy. Lower class patients, in particular, often fail to appeal to therapists; [8] consequently, by increasing the patient's motivation for therapy, he may become more attractive to the therapist, hence eliciting greater commitment, interest, and effort on the therapist's part.[9] Only in recent years has the importance of this point begun to be fully appreciated.

A Role Induction Film

The role induction procedure emerged as a promising technique. It seemed desirable to explore whether it might be possible to develop a role induction instrument which would combine the advantages of an individual interview with mass administration. Considerable savings in time and manpower might thus be effected. With these objectives in mind, we developed a documentary film, *Turning Point,*[10] which was subsequently evaluated under field conditions as an induction technique for lower class clients who were seen by various community agencies as requiring psychotherapeutic help to achieve their rehabilitation goals.

Turning Point is a dramatic story dealing with the life of a truck driver. Tom Sievier is a man in his early thirties whose major problem is a volatile temper which leads to open conflict with authority figures as well as with coworkers and his wife. Following a violent verbal interchange with the boss he gets fired from his job. Prospects for help from a mental health clinic, where Tom is seen in a preliminary interview by a social worker, impress Tom as dim. His pattern of uncontrolled aggressiveness leads to dismissal from several other jobs, and Tom's wife and children leave him. Tom reaches a state of despondency, turns to alcohol, and eventually contemplates suicide. Recalling a friendly interaction with a patient whom he had encountered at the clinic, he returns and joins a therapy group. A series of scenes showing the therapy group in action demonstrates how in the context of this experience Tom gains some understanding of his own contribution to the difficulties in his life. The film ends as Tom succeeds in applying these insights; he regains his original job and works out a more satisfactory relationship with his wife.

Evaluation

The effectiveness of *Turning Point* as an introduction to group psychotherapy was compared with that of a role induction interview conducted by a psychiatrist and the viewing of a neutral (control) film that had some relevance to prospective clients but was not seen as an induction procedure in its own right.

A role induction procedure facilitated a favorable therapy experience for lower class clients. The effects of the two comparable techniques (structured interview and sound film) were evident immediately following the induction session. They were reflected in the clients' attitudes toward the induction process, knowledge of group therapy including the respective roles of client and therapist, motivation to begin group therapy, expected improvement from therapy, and clients' attractiveness to their therapists.

The changes were maintained throughout therapy, as measured by numerous indices of satisfaction, progress, and in-therapy behavior. Perhaps most important, the clients' self-ratings of therapy outcome, improvement in specific target symptoms, and self-understanding achieved through therapy, as well as satisfaction with the treatment program, were enhanced by the role induction sessions. Similarly, therapists' post-therapy ratings of the clients' attractiveness favored those clients who had been exposed to the role induction training.

Not a single measure favored clients in the neutral group. It is important to emphasize that clients in the neutral condition had been initially comparable to those in the two role induction conditions, except that the former group had higher verbal ability and a greater proportion of whites—attributes typically associated with *better* therapy performance and outcome.

In general, participation in either of the two role induction procedures was clearly more beneficial than the neutral procedure. However, there were some differential effects of the two role induction techniques. The interview seemed to be superior in conveying a detailed knowledge of the process of group therapy. This was reflected in the clients'

immediate post-induction ratings, higher self-disclosure scores, and therapists' ratings of specific behaviors during the early therapy sessions.

By contrast, the film was superior over a wider range of measures. These included the clients' confidence in group therapy as a potential means of dealing with emotional problems in general as well as the belief that group therapy was the proper treatment for them. (The interview seemed to have an inhibiting effect on the latter measure: While it may have imparted a more detailed account of the client's role in therapy, it also seemed to arouse considerable anxiety or ambivalence about his actual participation in the therapy process).

Clients who viewed the film reported higher expectations of improvement, and they were rated by their therapists as having more realistic expectations about therapeutic change. During therapy, they reported greater satisfaction with their progress and their therapists rated them as exhibiting more appropriate behavior in therapy. At the end of therapy, clients in the film condition reported greater improvement in target symptoms and they expressed greater satisfaction with the therapy program as well as the helpfulness of the induction procedure.

Thus the role induction film seems to be a superior technique for introducing clients to group therapy as a treatment modality from which they might reasonably expect to benefit. To this must be added the efficiency of the film technique, the obvious advantage of a standardized procedure readily available for mass administration, and wide audience appeal to both men and women from the lower socioeconomic groups. Moreover, viewing a film in familiar surroundings is undoubtedly a highly acceptable first step for a reluctant or defensive client which might pave the way for a more relaxed face-to-face encounter with mental health professionals.

Tool For Counselors

The importance of adequately preparing clients for the experience of psychotherapy is frequently an issue of relevance to counselors working in social agencies, since they are often confronted with the task of creating an awareness in their clients of the need for psychotherapeutic help. Thus, it is frequently the counselor who provides the client with his initial exposure to the area. This project has documented the importance of these early contacts and provided agency workers with an efficient and effective tool for introducing prospective clients to the process and goals of psychotherapy. The reported results have demonstrated the utility of the role induction film, *Turning Point,* for this purpose.

In addition to its primary function of preparing the prospective client for psychotherapy, the film may prove useful for other purposes. Although the need for more adequate information is most acute among those currently in need of psychotherapy (especially if they are poorly educated or from the lower socioeconomic classes), many other individuals can benefit from it. Accordingly, the film may serve a useful function in educating the families of prospective clients, training agency workers who will be dealing with these clients and their families, and providing general information to the community.

In addition to clarifying the process of psychotherapy, the film serves to dispel misconceptions and prejudice which are abundant in all strata of the population but are particularly prevalent among relatively unsophisticated and uneducated persons. It clarifies the meaning of emotional problems in living as well as the procedures used for dealing with them, and it strongly emphasizes the need for *active* participation on the client's part in learning to cope with difficulties of which he has traditionally seen himself as the victim. Thus, the film paves the way for a conception of mental health in terms of mastery, competence, and self-direction.

Notes and References

(1) Szasz, T. S. *The Myth of Mental Illness.* New York: Hoeber-Harper, 1961.

(2) This paper is based on the SRS-supported research and demonstration project, "Preparing the Lower-Class Patient for Psychotherapy: Development and Evaluation of a Role Induction Procedure," RD 15–P–55164. Abstracts are available from the author. The final report is available from the National Technical Information Service, Springfield, Va., $3.

(3) Credit for pioneer effort in this area belongs to Dr. Martin T. Orne.

(4) Orne, M. T., and Wender, P. H. "Anticipatory Socialization for Psychotherapy: Method and Rationale." *The American Journal of Psychiatry,* 1968, *124,* 1202–1212.

(5) Hoehn-Saric, R., Frank, J. D., Imber, S. D., Nash, E. H., Stone, A. R., and Battle, C. C. "Systematic Preparation of Patients for Psychotherapy: I. Effects on Therapy Behavior and Outcome." *Journal of Psychiatric Research,* 1964, *2,* 267–281.

(6) Truax, C. B. *Counseling and Psychotherapy: Process and Outcome.* (Final Report: V.R.A. Research and Demonstration Grant #906–P) University of Arkansas, Arkansas Rehabilitation Research and Training Center, June, 1966.

(7) Hoehn-Saric. *Op. Cit.*

(8) Hollingshead, A. B., and Redlich, F. C. *Social Class and Mental Illness: A Community Study.* New York: Wiley, 1958.

(9) Strupp, H. H. *Psychotherapists in Action.* New York: Grune & Stratton, 1960.

(10) *Turning Point* is a black and white, 32 minute, 16 mm, sound film. Copies are available from the author.

NEW PUBLICATIONS

Research and Training Center (RT–13) University of Arkansas, Arkansas Rehabilitation R&T Center, Fayetteville, Ark. 72701.

The following publications have been received from RT–13: *Readings In Rehabilitation Research,* 375 pages; the following research reports: *Dimensions of Psychopathology: A Review of Factor Analytic Studies,* 11 pages; *Referral and Selection of the Public Assistance Recipient for Rehabilitation Services,* 24 pages; *Progress Report—Services Integration,* 55 pages; *Drug Abuse and School Children: A Survey and Analysis,* 35 pages; the following discussion paper: *A Review of Counseling Process Research In Rehabilitation Settings: Counselor-Client Interpersonal Functioning,* 26 pages; the following conference proceedings: *Symposium on the Criterion Problem in the Evaluation of Counselor Performance,* 36 pages; and the following monograph: *Introduction to Rehabilitation of Deaf Clients,* 76 pages.

Deaf Leadership Training for Community Interaction. Eugene W. Petersen, editor. Pub. No. (SRS) 72–25029. Social and Rehabilitation Service, 330 C St., S.W., Washington, D.C. 20201. 91 pages.

This is the report of the proceedings of a national workshop for deaf leadership on the State and local level. The workshop was sponsored by the National Association of the Deaf and supported in part through an RSA training grant.

The monograph brings together 12 papers written by leaders in the field of deafness. They comment on a wide variety of topics affecting and affected by the deaf clientele.

An Introduction To Working With The Aging Person Who Is Visually Handicapped. American Foundation for the Blind, Inc., 15 West 16th St., New York, N.Y. 10011. 51 pages. $3.

The following is quoted from the Foreword by M. Robert Barnett:

In recent years, there has been a sharp increase in the aged population in this country. With this increase, there also has been a steady rise in the number of blind and visually handicapped persons. This trend is expected to continue since it is estimated that more than 50 percent of all visual impairment occurs in the 65-and-over age group. Yet many programs and services, directed to either the elderly or the blind, do not meet the special needs of the aging blind person.

Keenly aware of this situation and wishing to help correct it, the American Foundation for the Blind, in 1969, appointed a National Task Force on Geriatric Blindness under the cochairmanship of Garson Meyer and Dr. Robert Morris, to address itself to this situation and to provide recommendations to the Foundation on national planning.

One of the early recommendations of the Task Force was that the Foudation develop printed materials that would provide basic information and education on the special needs of the aging blind for those persons who work with the elderly and/or blind. This publication is one result of that recommendation.

Rehabilitation of the Drug Abuser. Room 3218, Rehabilitation Services Administration, 330 C St., S.W., Washington, D.C. 20201. 122 pages.

A product of the Ninth Institute on Rehabilitation Services, this book covers the nature and extent of drug abuse, legislation, eligibility and feasibility, special considerations and needs of abusers, staff attitudes and counselor skills, and service programing. Among the appendices are a list of films, a bibliography, and a drug abuse products reference chart.

Vocational Evaluation and Work Adjustment Services In Vocational Rehabilitation. Room 3218, Rehabilitation Services Administration, 330 C St., S.W., Washington, D.C. 20201. 92 pages.

This work is one of the products of the Tenth Institute on Rehabilitation Services.

The guide is intended to provide assistance to the counselor in making appropriate selection and use of vocational evaluation and work adjustment programs.

It discusses the processes, reports, personnel, and counselor/facility specialist/agency responsibilities in evaluation and adjustment services.

Curriculum Guide for Interpreter Training. Martin L. H. Sternberg, Carol C. Tipton, and Jerome D. Schein. Deafness Research and Training Center, School of Education, New York University, New York, N.Y. 64 pages.

After a general look into deafness and interpreting, the guide looks into specific aspects of interpreter relationships (ethics, client relations, linguistics, physical settings, etc.) and then devotes sections to interpreting in various settings, such as educational, mental health, legal, and religious.

Emergency Medical Services: Behavioral and Planning Perspectives. John N. Noble, Jr., Ph. D., Henry Wechsler, Ph. D., Margaret E. La Montagne, M.S.N., and Mary Ann Noble, D.W. Sc., editors. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y., 10025. $24.95.

This book provides a wide-ranging compendium of 48 papers that combine essential historical and recent studies bearing on the adequacy of the emergency medical care system and ways of improving it.

The articles provide analytical methods for predicting the problems which regularly beset the emergency medical care system. They

(*continued on page 37*)

Wheelchair Deco

Wheelchair decor winners: On front cover Mrs. Bobbie Giauque, left, Brent Gauthier, middle, Linda Hunter, and right Dora L. Stump.

Four persons, the tops in their age categories, were honored at an awards ceremony held in the Statler Hilton Hotel in Washington, D.C., on May 16, 1973. They were the first-place winners in a nationally-conducted Wheelchair Decor contest that drew over 1,000 entries from every State in the U.S. Participation in the activity, however, involved even larger numbers of persons since 160 local competitions sent forward their winning entries and thousands more people got involved in helping decorate and in advising on decorations.

Brent Gauthier of Anchorage, Alaska, represents the winner for the young set, ages 4 through 12; other winners: Linda Hunter of New York (ages 13–21); Mrs. Bobbie Giauque (pronounced Juke) of Utah (ages 22–25); and Mrs. Dora L. Stump of California (ages 55 and over). Each of them received $500 in cash, their trip to the Nation's Capital, and, as an added bonus, a personal meeting with Mrs. Nixon at the White House. The winners and their entries are pictured on the cover and in these pages.

The contest is the brain-child of Susan and Rex Taylor and their family, and it had the financial support of Mutual of New York (MONY) in addition to endorsement by many governmental and private organizations.

"The idea of the contest," according to Mr. Taylor "is to let handicapped people know that they can, with a little ingenuity, convert their 'cage of chrome' into attractive as well as functional aids to their lives. Instead of turning people off—and a person in a wheelchair certainly doesn't need that!—the chair can draw disabled and nondisabled people together."

Among the clicking of shutters and the whirring of TV cameras, the awards were presented by MONY Board Chairman, Richard I. Fricke, and Harold Russell, Chairman, President's Committee on Employment of the Handicapped. In each category, there also was second and third place winners who received, respectively, $250 and $150 cash awards. Additionally, honorable mentions were recognized in each category. But,

cor Contest Winners

again, in the words of a resident of the Shady Lane Nursing Home in Wadena, Minnesota, "This is one contest in which heads, we win, or tails, we win."

Among the many disabling conditions represented, were large numbers of persons with para- and quadriplegia, polio, muscular dystrophy, cerebral palsy, spina bifida, and multiple sclerosis.

The idea of wheelchair decoration has personally worked wonders for Susan Taylor, a Connecticut housewife and multiple sclerosis victim. She, her husband Rex, a communications consultant, and her family hoped the contest they created would serve as "a ray of hope to others." She remembered: "Once I had put a little color and personality into my chair, somehow my whole attitude toward the chair changed."

Or as one official at the Kansas Neurological Institute commented: "We feel it (Wheelchair Decor) is an opportunity for a very important minority group to say, 'Hey, look at me, I'm special!' "

Either alone, or with other's help, contestants designed and attached colorful materials and patterns to their chairs. Snoopy, smile faces, American flags, floral, and auto motifs were prevalent among the entries. Hobbies and skills, such as gardening, fishing, playing cards, needlepoint, crewel, applique, leatherworking, and painting were reflected. After the design was completed, color snapshots were then taken and sent in by mail to Wheelchair Decor headquarters.

In addition to those represented here, some of the motifs were quite original. For example, one woman's entry showed a surrey with a fringe on top. Others included a Mexican cart with its occupant appropriately attired in sombrero and serape, psychedelic designs aplenty, and a man whose proclivity for girl watching was duly recorded on the back of his chair.

Final judging took place in April in New York City. The entries were evaluated on originality, attractiveness and individual effort by a panel of experts from the fields of design, fashion, art, and photography.

EVALU

Evaluating Workshop Evaluations

Simon Olshansky

"For all argument must rest upon premises more fundamental than the conclusions."—A. N. Whitehead.

There is increasing interest in and concern for the evaluation of clients within workshops. In response to this growing interest and concern, the National Rehabilitation Association with RSA sponsorship has begun a 3-year study. It is timely, therefore, to review the guiding assumption which influences and directs the evaluation process.[1 2] The problem is not how to make the evaluation better, but to see it in proper terms, in terms which will best serve the interests of most clients.

The Guiding Assumption

The guiding assumption held by many professionals is that a person has abilities, aptitudes, and attitudes, much as he has bodily organs, which can be rather easily tested, evaluated, and revealed within 1 to 8 weeks. Many workshops use 2 to 4 weeks, as an average. While workshop evaluations represent a happy change from pencil and paper tests, what continues unhappily is the old assumption that the personal qualities stated are *given* and, by and large, unchangeable.

With an incredible innocence, many professionals in vocational rehabilitation think that as a result of a brief evaluation period they have achieved a valid and valuable picture of what the evaluees can do or learn to do in terms of work. They fail to acknowledge the limited value of the evaluation process as practiced, limited by the time and place, and by the activities and circumstances involved in each evaluation procedure. How, for example, does one evaluate the impact of the evaluator on the evaluee? Or the general setting within which the evaluation takes place? Or the dull and discontinuous tasks a client must do? Or the tension and anxiety produced by the experience of undergoing an evaluation? Or that he may be an unwilling subject? In addition, many professionals fail to see that the traditional evaluation process is an expression of professional power: the "superior" person testing the adequacy and suitability of the "inferior" person.

More important, they fail to appreciate that many clients, given

(*continued on page 24*)

Mr. Olshansky is Executive Director, Community Workshops, Inc., Boston, Mass.

The writer wishes to thank Helen Olshansky for her editorial help and her stubborn courage in insisting on certain changes.

ATION

A Critical Response

Paul R. Hoffman, Ed. D., and David W. Corthell, Ed. D.

Simon Olshansky's latest article needs to be studied by vocational evaluators who feel their programs do not need improvement; facility administrators who do not hire qualified vocational evaluators or provide inservice training in evaluation for new staff to the field; and rehabilitation counselors who do not determine the adequacy of a facility service.

There are elements of truth in the article. However, it contains gross errors, overstatements, and unfounded charges. Consequently, it cannot go unchallenged. It needs to be challenged on the basis of (1) conceptualization or theoretical base, (2) specific issues, and (3) the writing strategy of Olshansky.

Challenge I—Conceptualization

Olshansky's introduction and title suggest his paper will discuss workshop evaluation. Instead, his diatribe discusses isolated bits of vocational evaluation, work adjustment, and extended employment. Further, he has ignored much of the current thinking and literature on vocational evaluation and work adjustment, as exemplified by such writers as Barton,[1] Dunn,[2] Hoffman,[3] Lashner,[4] and Nodolsky.[5]

The Tenth Institute on Rehabilitation Services was assigned vocational evaluation and work adjustment in vocational rehabilitation as its subject areas for study. Hoffman prepared definitions for vocational evaluation and for work adjustment which were accepted with minor modifications by the committee and published in the IRS publication.[6] These are worth including here in order to clearly differentiate between the two processes. For a more comprehensive discussion, the reader is referred to the IRS document.

Vocational evaluation is a comprehensive process that systematically utilizes work, real or simulated, as the focal point for assessment and vocational exploration, the purpose of which is to assist individuals in vocational development. Vocational evaluation incorporates medical, psychological, social, vocational, educational, cultural and economic data in the attainment of the goals of the process.

(*continued on page 26*)

Dr. Hoffman is Professor of Education and Chairman, Department of Rehabilitation and Manpower Services, University of Wisconsin-Stout. Dr. Corthell is Associate Professor of Education and Training Director, Research and Training Center in vocational rehabilitation, University of Wisconsin-Stout.

Client at Community Workshops, Inc., Boston, works on a printed circuit board.

timely and appropriate opportunities, can grow, improve, and achieve a higher level of work performance. The challenge is to develop whatever talents clients may have rather than to evaluate them. We can never know what potentials for growth people have unless and until they have had the opportunities.

Strategies for Developing a Person's Potential

The problem is how to change behavior, not how to evaluate it. Our interest has to shift from evaluation to developing and fulfilling whatever potential a person may have. What a person can do is unknown and unknowable until he has had an opportunity which interests and challenges him enough to encourage him to exert himself. The gnawing question to professionals should be how adequate and appropriate is the opportunity. In the past, with insufficient consideration of the quality of the opportunity offered him, the question was how adequate is the person.

What are some specific strategies helpful in developing a person's potential? These strategies are predicated on respect for a person as autonomous, with the right and responsibility of decision making. If he is expected to act as an adult in the labor market, he should be accorded the right and responsibility of decision making. A person should come to a workshop because he wants to and stay because he wants to. Coercion to enter or stay in a workshop is likely to limit or defeat chances for success. Moreover, attention should shift from past to present, for a person's history, while of interest, does not always define or suggest his present potential for growth.

First, to develop work capacity there has to be available a wide variety of interesting and challenging work tasks [3] of varying complexities. Dull and repetitive tasks do not challenge work capacity, but one's capacity to stay awake. That so many clients tolerate so much boredom day after day suggests the extent to which we have intimidated them. While it is true that many workshops have difficulty finding suitable work, such difficulty should not lead us to pretend that the kind of work available makes no difference. Dull work can only dull most workers, diminishing their interest in their workshop experience.

Second, we should reward clients realistically for their efforts, not with words of praise, but with good American money, which speaks so much more persuasively than words. Paying clients 25¢ per hour is not likely to encourage much exertion. If shops lack the means to pay more, they should not misrepresent the token amounts as wages. The small sums might be called travel and lunch allowances.

Third, we should expect clients to perform as *normal* workers, always insisting that they observe the rules of *normal* behavior. To expect less than normal behavior is to encourage abnormal behavior. Most clients will respond to the shop message if it is unequivocally clear. To indulge clients is to confuse them and to diminish their capacity to behave normally. That some clients cannot meet normal expectations at different points of time does not make the expectation less important, but quite the reverse; the client has to be aware of his departures, for whatever reason, from normal behavior.

Time Requirements

Evaluations generally are of a predetermined duration. Unfortunately we cannot state in advance the time required to develop any person's potential. For a small number of clients, 2 months may be more than adequate; for a larger number, a year may be required; for a few, years may be required. For one client, at Community Work-

shops, 3 years were needed; for another, 6 years.

The question arises: When does one surrender and recognize that a client lacks the potential for regular work? Admittedly the danger exists that our own hopes and need for success may deceive us and lead us to believe a client has potential for regular work when in truth there is none. There is no remedy for this kind of self-deception except continuing review, study, and discussion of each person within the rehabilitation process. If there is a danger of believing there is potential where none exists, there is even a greater danger of denying potential because of a quick evaluation of 8 weeks or less. Better by far to waste money and time than to run the risk of selling another person short. Many persons coming to workshops have already been cheated by fate, nature or history. Should we cheat them again by denying them an appropriate opportunity? Are we in rehabilitation to build hope or to bury it? Are we more intent on putting clients down than helping them stand up?

Two Populations Considered

If we relate the traditional evaluation process to the mentally ill and retarded, two populations referred to DVR in large numbers, we can see more clearly its inadequacy.

For example, the problem with many of the mentally ill is not so much their inability to perform work tasks; rather it is their inability to manage themselves and to manage their relations to others. The professional responsibility is not just to evaluate their work ability, but to help them feel better about themselves, to develop more self-respect and self-confidence. Such an outcome requires much time, along with much encouragement and reassurance. In addition, they need repeated opportunities to experience themselves as better and more competent persons. Finally they have to learn to manage their anxiety with more efficiency and effectiveness.

The mentally retarded (the educable) have a different kind of problem. In large measure they have been persuaded that they are stupid and hopeless. The challenge is to help them change their image of themselves and to persuade them that for many tasks they are neither stupid nor hopeless. To develop their potential through appropriate experiences is to give them the opportunity they have been denied. Professional people deceive themselves in thinking that they are taking a significant and sophisticated step forward when they substitute a short work evaluation for a pencil and paper evaluation. In both instances they are exploiting the person's past with his many limitations, rather than exploring his future with his many possibilities. To evaluate these two populations in the traditional way is to enhance their anxiety and confirm their fears of incompetence.

An Ongoing Process

Evaluation should be a continuing companion to the developmental process rather than an isolated stranger intimidating the new client. At least each week the developmental process should be evaluated to see if it is appropriate to the person's changing needs, capacities, and interest. The focus of attention shifts from the person to the process. If the person fails to progress, the appropriateness and adequacy of the opportunity should be questioned. In the traditional evaluation, the adequacy of the person is questioned. In the developmental process, progress and problems are carefully noted and evaluated; and changes made are based on the ongoing evaluation accompanying the rehabilitation effort.

At the end of the developmental process, a defensible evaluation [4] states as completely and as carefully as possible the kinds of interventions offered and the kinds of responses effected. As a consequence of abandoning the traditional evaluation process, evaluation becomes *subordinated* at all times to the developmental process, with the goal becoming one of changing persons rather than evaluating them.

Client operates drill press at Community Workshops, Inc.

Notes

(1) For a discussion of the traditional evaluation process, see *Work Evaluation in Rehabilitation,* Walter A. Pruitt and Ralph N. Pacinelli, editors. Stout State University, 1969. Reprint Series RS–70–2.

(2) For a different point of view, see *The Principle of Normalization in Human Services,* Wolf Wolfensberger, editor. National Institute of Mental Retardation, Toronto, Canada, 1972.

(3) The use of work samples, increasingly popular, suggests insensitivity to the client's plight. He comes to the workshop with the serious intention of becoming a worker. Instead of doing real work for money he is asked in effect to play at being a worker, to perform contrived tasks which are likely to provoke anger and resentment and to measure his anxiety more than his work capacity.

(4) It should be pointed out that some professionals prefer the term assessment to that of evaluation. Whatever term is used the intent is the same: to exclude quickly *seemingly* unlikely candidates from further services. The hastily and improperly achieved outcome is then used to justify and legitimize their exclusion, which is unjustifiable and illegitimate. In theory or in practice the wrong answers are certain to follow the wrong questions. The traditional evaluation process, however carefully and competently constructed or controlled, asks the wrong questions.

Work adjustment is a treatment/training process utilizing individual and group work, or work related activities, to assist individuals in understanding the meaning, value, and demand of work; to modify or develop attitudes, personal characteristics, and work behaviors; and to develop functional capacities, as required, in order to assist individuals towards optimum development.

The current thinking and literature, while differentiating between the processes, notes their similarities, shared goals, and indicates they are not mutually exclusive. However, clear differentiations are made so more effective programing is permitted.

Olshansky refers to the "traditional evaluation process," but fails to define what he means other than to refer to a single reference source by Pruitt and Pacinelli.[7] From a careful reading of his article and interpreting his complaints, it can be concluded that he believes the "traditional evaluation process" to include (1) assessment prior to placement in a workshop, (2) limitation of the assessment process to a relatively short period of time, and (3) nonpayment of money to the client for participation in evaluation. Olshansky claims to offer a reconceptualization of the evaluation process or a new model. Instead, he postulates a process that has unfortunately been practiced in some workshops for many years. It is a process that: (1) enters a client into the workshop program without prior assessment or development of a program, (2) fails to delineate between vocational evaluation and work adjustment, and (3) doesn't differentiate between the goals and objectives of vocational evaluation and the program monitoring that must accompany work adjustment. In reality, it is this latter process that has been "traditional" in too many workshops, but has fortunately been rejected by more sophisticated workshops in favor of the process outlined above.

In actuality, Olshansky does not even offer a model of vocational evaluation. His own statements indicate that he is referring to the process of work adjustment. "The problem is how to change behavior, not how to evaluate it." "Our interest has to shift from evaluating to developing and fulfilling whatever potential a person may have." Further, he discusses "strategies for developing a person's potential" and not for evaluating that potential. These statements indicate objectives that are in line with the primary objective of work adjustment, that is, change of behavior. They are not in line with the vocational assessment and exploration objectives of vocational evaluation.

A common, but extremely important, point of confusion by Olshansky is the failure to differentiate between vocational evaluation per se and the evaluation or program monitoring which must accompany the work adjustment process. Correctly, Olshansky points out the necessity of program monitoring in order to determine the effectiveness of the work adjustment program. However, he labels this as the evaluation process which DVR counselors are expected to purchase as vocational evaluation. He fails to note any differences in the objectives of this type of program evaluation and vocational evaluation.

Hoffman [8] and Chapter II of the IRS document referred to earlier,[9] delineated the differences in objectives between vocational evaluation per se and the evaluation process accompanying work adjustment. The objective of vocational evaluation "is to assess a wide range of factors and to make recommendations for rehabilitation. Such recommendations may include: (1) direct placement; (2) education; (3) on-the-job training; (4) work adjustment; (5) placement in such programs as extended sheltered employment, work activity, or day care; or (6) not feasible for continued rehabilitation services." [10] The model proposed by Hoffman includes reevaluation from time to time when the client is placed in category five.

The objective of the program monitoring (evaluation) process during work adjustment "is to: (1) observe behavior and performance; (2) determine progress towards the goals of the adjustment program; and (3) recommend needed changes, or termination when work adjustment is completed." [11] To some this may seem like "nit picking," however, the objectives are different. Until we can carefully delineate between our activities, we cannot adequately research our efforts in order to improve services to clients, nor can we establish programs that will operate at their maximum efficiency.

Finally, it needs to be stated here, as in other recent literature, that vocational evaluation is needed prior to any work adjustment program in order to develop a planned program of work adjustment. This evaluation can take place in a formal evaluation unit, in a workshop using the first few weeks as a period of observation and evaluation, or, in some cases, in a rehabilitation counselor's office. It is important that problems be determined, base lines set when possible, and necessary programs to modify client behavior determined. As Campbell and O'Toole [12] so aptly indicate, the treatment program must vary with the problem. Olshansky with his stress on the need for program monitoring of the adjustment of development process is a proponent of effective programing. However, he completely fails to deal with the problems of determination of the type of adjustment or development process needed and exactly what variables are to be monitored.

Challenge II—Specific Issues

1. *Guiding Assumption:* Olshansky stated that the "guiding assump-

In the "work world" many jobs are dull and repetitive, therefore, needed in realistic vocational evaluation. Such tasks can provide very meaningful data for vocational evaluation as to frustration tolerance, work habits, ability to follow routine....

tion, held by many professionals, is that a person has abilities and attitudes, much as he has bodily organs" and that these "qualities . . . are given and by and large unchangeable." Without saying so directly, he suggests that this assumption is held by evaluators who disagree with his position. Ridiculous! This assumption was true in early psychological testing theory, but few would advocate such a concept today.

In the field of vocational evaluation, the emphasis is on serving the person, accurately assessing the current level of vocational development, determining vocational potentials, assisting the handicapped person in vocational exploration, and maximizing further vocational development. The questions asked in vocational evaluation are: (1) is the client ready for job placement or training? (2) if so, what job or training? (3) if not, why not? and (4) what treatment plan might bring about client and/or environmental changes so the client can make decisions and enter the vocational field? [13]

In this section of his paper, Olshansky indicates evaluators believe a brief evaluation period will yield a valid picture of a handicapped person. He challenges this point, stating that such evaluations fail to account for such factors as effect of evaluator-evaluee relationship, effect of tension generated by dull and discontinuous task, etc. Evaluation, in the hands of improperly trained evaluators and in inadequate programs, has these defects. The same is true, however, in the type of workshop program suggested by Olshansky if that staff is also inadequately trained. Effective evaluation programs include observation and evaluation for such factors as skills, dexterities, aptitude, attitudes, interpersonal relationships, work habits, and environmental effects. Vocational evaluation can be accomplished in a relatively brief period as the necessity for specific work adjustment will be recognized quickly for severely handicapped clients. Referral back to a formal vocational evaluation may be the next step in the rehabilitation process for clients who have completed extensive adjustment and developmental programs.

2. *Strategies for Development:* Olshansky is guilty of creating what is referred to in behavioral terms as "fuzzies." He labels something as development, suggests a treatment-type program, but then attempts to criticize vocational evaluation.

His first strategy is to provide a "wide variety of work tasks of varying complexities which would interest and challenge the client." No one can argue with the point that too often workshops have only dull and repetitive tasks. In fact, we believe workshops with only very limited tasks should be either limited in utilization by rehabilitation counselors or not used at all. Such programs may best be limited to work activity centers.

He fails to indicate how workshops can develop greater capacity for evaluation, such as through the use of work samples and job tryouts. But then, he is primarily concerned with work adjustment or development. He believes dull and repetitive work has no place in evaluation and rehabilitation. Work may be dull and repetitive for one person and not the next. In the "work world" many jobs are dull and repetitive, therefore, needed in realistic vocational evaluation. Such tasks can provide very meaningful data for vocational evaluation as to frustration tolerance, work habits, ability to follow routine, etc.

The second strategy recommended is rewarding clients with realistic wages. Wages in work adjustment programs and wages beyond the extreme minimal found in some workshops are highly desirable. Money, however, is not always the most valuable reinforcer. For example, praise and a sense of accomplishment or purpose can be extremely rewarding. Further, while wages in work adjustment programs are desirable, wages are not needed to obtain client interest and motivation in comprehensive vocational evaluation programs.

His third strategy consists of utilizing the standard of "normal behavior." Again, while claiming to reconceptualize vocational evaluation, he refers to the development process. Vocational evaluation attempts to assess the person where he is and to predict his vocational potentials. This difference strongly indicates the need for evaluation prior to adjustment in order to help determine the client's level of vocational development, describe untoward behaviors objectively, and recommend a treatment plan.

3. *Time Required:* Olshansky's problem seems to revolve around the length of vocational evaluation. Some workshops, without adequate evaluation programs, claim vocational evaluation cannot be adequately completed in 2 to 4 or even 6 weeks. Instead, they state clients must be referred for a longer period of study at higher cost. We believe it is unfair to clients, referral agencies, and the profession to subject clients to development or adjustment programs which are longer

than necessary. Programs become unnecessarily long because specified individualized client goals were not specified before beginning. Consequently, adjustment training may take years as suggested in the article.

Olshansky seems fatalistic where he stated, "when does one surrender and recognize that a client lacks potential for regular work?" The purpose of vocational evaluation is not to surrender at once. Instead, it is to determine if there are potentials and/or other ways of treating the problem. The Evaluation and Training Center staff at the University of Wisconsin-Stout see many clients who, at first glance, seem "hopeless" and for whom "surrendering" appeared to fit. Yet they respond to the comprehensive vocational evaluation program and vocational exploration programs developed for them. Olshansky states his typical client is either retarded (educable) or emotionally disturbed. It is true that many clients with these handicaps need a prolonged work adjustment program. However, they also need a few weeks of prior evaluation in the facility where the emphasis is observation-evaluation-development of a treatment plan and not immediate adjustment. Possibly the reason Olshansky finds himself limited to this type of referral is because he lacks a comprehensive vocational evaluation program.

He also stated it is "better by far to waste money and time than run the risk of selling another person short." This is a very noble statement which is difficult to argue against. Unfortunately, in these days of tight fiscal restraints, his attitude is a luxury we can ill-afford in both financial and manpower resources. We need to determine the most effective way of serving people with a constant eye upon cost/benefit ratio. Placing a person with competitive employment potential in a workshop and keeping him there for prolonged periods is a disservice to the client and a cost which cannot be borne by State-federal programs. Effective vocational evaluation should and can assist us in this matter.

Challenge III—Writing Strategy

Olshansky's strategy in this and other articles appears to be attack, confuse, and appeal to the sympathy of the reader. The Olshanskys of our world are colorful, interesting to listen to and read, and sometimes play a vital role in our society. However, it may be time to challenge Olshansky. In this article he used extreme statements (e.g., "superior person," "incredible innocence") and made some grossly false and extreme charges. One of these being the charge answered earlier in this response about evaluators seeing aptitudes, etc., as bodily organs and unchangeable.

In his section on guiding assumptions, he refers to the evaluation process as an expression of professional power and of the superior person over the inferior person. Unfortunately, the charge is not completely unwarranted. Vocational evaluators are urged to read and ponder over this charge and to take action to change if the "glove fits." Workshop personnel and rehabilitation facility directors should also do a careful self-examination, because the malady is not limited to evaluators. Feelings of superiority over others infects people in all professions, therefore; it is grossly inaccurate and unfair to single out vocational evaluators and the evaluation process on this charge.

In his section on two populations considered, he again makes a blanket change, ". . . professionals are exploiting the person's past with his many limitations, rather than exploring his future . . ." By implication, Olshansky suggests vocational evaluators contribute to the retarded person's feelings of being "stupid and hopeless." Again, he has failed to understand the vocational evaluation process and has made gross statements which are inaccurate, unfair, and which cannot go unchallenged.

If Olshansky continues in the style of his recent articles (see "Six Scandals in Vocational Rehabilitation." *Rehabilitation Record,* January–February 1973) [An additional response to "Six Scandals . . ." is carried in this issue; see Isadore Salkind.–Ed.], then perhaps his usefulness as a "gadfly" is over. The very use of the word "scandal" is grossly inappropriate. Rehabilitation as a profession, vocational evaluation, and other rehabilitation processes need to be challenged and prodded into constant improvements; however, such articles, as recently seen from Olshansky, may also do rehabilitation and its process grave injustices and immeasurable harm as a result of such strategies.

References

(1) Barton, E. "Evaluation's relation to adjustment." *Vocational Evaluation and Work Adjustment Bulletin,* 1970, 3(2), 2–6.

(2) Dunn, D. "Work Adjustment, work evaluation, and employability." *Vocational Evaluation and Work Adjustment Bulletin,* 1971, 4(2), 11–16.

(3) Hoffman, P. R. "Work Evaluation and adjustment: The relationship." *Journal of Rehabilitation,* 1971, 37(4), 19–21.

(4) Leshner, S. "The relationship of work evaluation to work adjustment training." *Journal of Rehabilitation,* 1970, 36(1), 32–34.

(5) Nadolsky, J. "Evaluation's relation to adjustment." *Vocational Evaluation and Work Adjustment Bulletin,* 1970, 3(2), 2–6.

(6) U.S. Department of Health, Education, and Welfare, RSA, Tenth Institute on Rehabilitation Services. *Vocational Evaluation and Work Adjustment in Vocational Rehabilitation,* 1972.

(7) *Work Evaluation in Rehabilitation,* Pruit, W. and Pacinelli, R., eds. Washington, D.C.: Association of Rehabilitation Centers, 1969.

(8) Hoffman, *op. cit.*

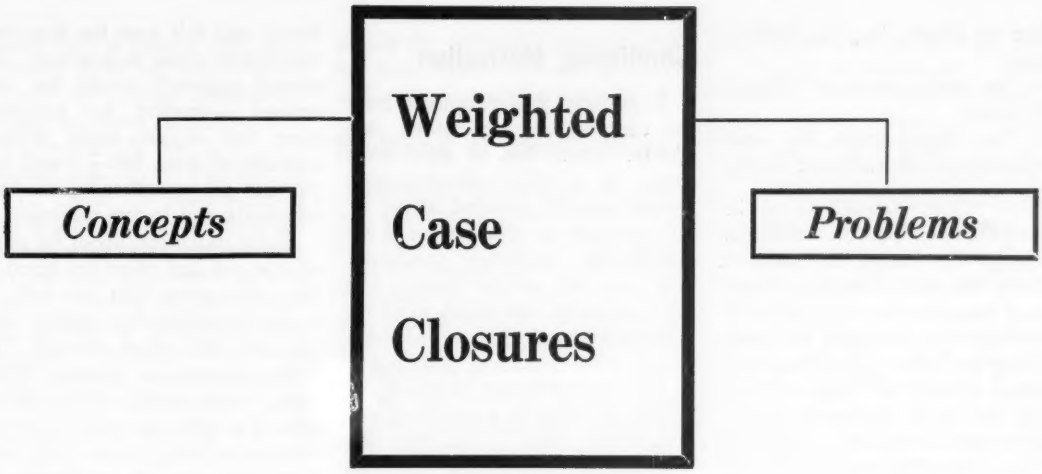
(9) DHEW, *op. cit.*

(10) Ibid. p. 8.

(11) Ibid. p. 8.

(12) Campbell, J., and O'Toole, R. *Work Adjustment: A Dynamic Rehabilitation Process.* Cleveland, Ohio: Vocational Guidance and Rehabilitation Service (N.D.)

(13) Roberts, C. "Definitions, objectives, and goals in work evaluation." *Journal of Rehabilitation,* 1970, 36(1), 12–15.



Ronald Conley, Ph. D.

The case closure system utilized in the State-federal vocational rehabilitation program is generating growing dissatisfaction among all who deal with it. This unweighted system gives equal credit to counselors and to States for each rehabilitation achieved. Opposition to it derives from two major problem areas. The first of these is that it motivates some counselors to behave in ways that are not in the best interests of the disabled. Specifically:

• It encourages them to avoid serving persons who would require a great deal of counselor time or for whom the probability of success is below average. High priority groups, such as the severely disabled, mentally retarded, alcoholic and drug abusers, criminal offenders, and persons with behavioral problems are especially likely to be discriminated against since these groups require considerably more counselor time than the average rehabilitant. Also their chances of vocational success are considerably below average. The allegedly common practice of "creaming" is a result of this motivation.

• It encourages the selection of easily attained goals rather than those which would be in the best interest of clients. Easily attained goals require less counselor effort and have a higher probability of being achieved. In 1970, the earnings of over half of all rehabilitants (among those with earnings) were below the poverty level at closure. Over 15 percent had no earnings at closure. One wonders: Would vocational achievement have been higher had counselors been given credit according to the quality of the placement?

• Counselors may be influenced by the system to prematurely close cases to achieve a given number of rehabilitations. Conversely, among counselors who have achieved their "quotas," the system may influence them to retain vocationally placed clients on the caseload so that placements can count towards the following year's rehabilitations.

The second problem area is that an unweighted system is a poor basis for comparing the rehabilitation efforts of States, counselors or the program itself over time. Counselors and States serving large numbers of the severely disabled and other priority groups may, in fact, be doing a superb job although numbers of rehabilitants may be below average.

The development of a weighted case closure system has been under discussion for a number of years. Yet, to date, no generally acceptable method has been formulated.

Factors in Weighting

At least four major factors must be considered in developing differential weights for rehabilitation closures. They are:

• The probability of success in rehabilitation. This is the "risk" factor in accepting clients.

• The time expended by coun-

Dr. Conley is Director, Division of Monitoring and Program Analysis, RSA.

selors on clients, i.e., the "effort" factor.

- Case service costs or "resource use" factor.
- The improvement in social well-being or "client change" factor.

The "client change" factor includes far more than the traditional earnings or change in earnings. Among the many benefits of vocational rehabilitation that should be considered are increases in homemaking and other unpaid work performed around the house or away from the home (volunteer work); and improved mobility, social skills, physical condition, capacity for self care, family life, and home environment for children of clients. To be considered also is a reduction of public dependency and increased client and family happiness and self-respect.

Client change, then, measures the "quality" of rehabilitation and includes both vocational and nonvocational benefits.

All of these factors vary substantially with different demographic characteristics. It is these variations that provide a rationale for a weighted case closure system and that also greatly complicate the task of formulating a generally acceptable system.

System Development Problems

These factors must somehow be combined to develop a weighting system, a complicated and formidable task. There is no single, best system. In fact, different systems may yield dramatically different results; yet, at the same time, there may be little objective basis to prefer one or the other.

There are three types of system development problems. They are: 1) the conflicting motivation for differential weights, 2) the problems of measurement, and 3) the problem of combining measures of the variables used.

Conflicting Motivation

In addition to developing a basis for comparisons, a weighted case closure system has at least three goals: 1) to reduce discrimination against severely disabled clients, 2) to encourage an efficient use of rehabilitation resources (counselor time and case service funds), and 3) to stimulate counselors to set rehabilitation goals that are commensurate with vocational potential.

The *probable* ways in which the factors involved in a weighting system would affect the weights and the potentially conflicting effects of these goals are reviewed below.

The greater the probability that a client will be unsuccessful (the risk factor), the greater the weight that would be given to a successful closure, *if* the goal is to prevent discrimination against high risk referrals. This risk probability must be calculated on the basis of the percentage of persons in a particular demographic group who do not succeed in their rehabilitation efforts, since individualized estimates of risk are possible only on a highly subjective basis.

The greater the amount of counselor time required for a client (the effort factor), the greater the credit that should be given for a successful closure, *if* the goal is to prevent discrimination against cases that require a disproportionate amount of counselor time. The weight would not simply increase, however, as the time spent on each individual case increases—this would reduce the incentive to close a case and move on to other cases. There are two possibilities: 1) Calculate the average amount of time required for each demographic group and compute weights on that basis or 2) calculate the ratio of actual time spent on a case to the average time for a case in that demographic group. If this ratio equalled one, the weight applied to the case would be identical to the first possibility. If this ratio exceeded one, the weight would be lower, and if it were less than one, the weight would be increased. The second approach would not only reward counselors for accepting cases that require above average amounts of time, but it would also provide an incentive to use time efficiently and to the maximum.

These statements about the effect of case risk and effort are based on the assumption that we wish to avoid discriminating against high risk and high effort referrals. This is the conventional approach. However, it may conflict with the second goal of a weighting system since acceptance of high risk and high effort cases may not be considered the most efficient use of resources.

There is no conventional wisdom about the use of case service costs in a weighting system. High case service costs could cause weights to increase, *if* we wished to encourage counselors not to discriminate against these cases; or they could cause weights to decrease, *if* we wished to encourage economy in the use of scarce rehabilitation resources.

Another way of using case service costs to encourage efficient program operation would be to reduce closure weight if the case service costs of a client exceeded the norm for his demographic group (or, say, 120 percent of the norm). This could be done on a case by case basis or on all closures by a counselor (adjusted for demographic characteristics which would cause high costs). The second alternative would cause a uniform increase in the weights for all of a counselor's closures.

Obviously, the larger the client benefits, the greater the weight ascribed to the closure. *If* we wish to avoid discrimination against the severely disabled, these weights should be established on the basis of the norms determined for each demographic group. For example, a greater value would probably be given for placing a trainable retardate in a job paying $50 per week (above the norm for trainable retardates) than for placing a college

graduate with a missing limb on a job paying $100 per week (below the norm for college graduates). The goal, for either alternative, is to avoid unreasonably low client gains. It is quite possible, for example, to offer no credit for placements of clients in jobs that pay less than the minimum wage or at least to offer credit for such placements only in the case of severely disabled clients.

The goals of a weighted system often conflict with each other. Even the goal of efficient use of rehabilitation resources may conflict with other goals since efficiency may be achieved in two ways. In the first, we can seek to bring each client, whether severely or mildly disabled, to an appropriate vocational level (goal 3) in the most economical manner, which does not conflict with other goals. And in the second, we can discourage services to high risk, high cost or low return clients, which directly conflicts with the nondiscrimination goal (as observed above). Resolution of the way in which different variables will be used to influence weights will ultimately be based on the personal judgments and goals of those persons who determine program policy.

The process of devising weights becomes even more complicated and subjective when the following questions are asked:

- Should additional weight be given to closures of clients with high priority disabilities, such as public assistance recipients, alcoholics, drug abusers, etc.?
- Should weights be increased in areas of high unemployment?
- Rehabilitation counselors may soon become responsible for long term follow-along services for high-risk clients. There will be no closure in the traditional sense. How shall credit be given for these cases?
- Should the weight for a "repeater" rehabilitant be reduced on the grounds that important services were received previously? If so, should the reduction depend upon the time elapsed between the current and the previous rehabilitation?

Problems of Measurement

Measuring the variables entering into a weighted closure system is a formidable task. The first problem is to define the various factors involved in measuring case risk, effort, cost, and client change. The definitions of risk and case effort are reasonably straightforward.

Case cost, however, raises many issues. If indeed we are concerned about the efficiency of resource use, then the relevant costs are "social" costs, i.e., the total use of resources attributable to rehabilitation services and not case service costs alone which represent only the resources directly expended by counselors. In order to calculate social costs, we would need to add resources expended by other agencies and by the client or his family to case service costs. Maintenance expenditures, on the other hand, must be deducted on the grounds that they do not represent a use of resources but a transfer of resources.

Although a wide range of client change variables can be identified, a simple listing of these variables is not, of itself, a major problem.

The second problem is to develop instruments to measure these variables. The greatest problems (other than the effort involved) are caused by the client change variables. These measurements require that we estimate the *change* due to rehabilitation by comparing the level of functioning of the client after services with what would have happened had services not been provided. This presents great, in some cases, insurmountable problems.

At the time of closure or subsequent followup, earnings is the only client change variable, which can be measured precisely and easily. Instruments for measuring homemaking services are, as yet, rudimentary. Most other client change variables can be measured, if at all, only by elaborate questionnaires of questionable validity. The development of a method of measuring social cost is also yet to be accomplished, and it may prove to be a formidable conceptual task to determine when privately borne medical and training costs are rehabilitative (and, therefore, part of social costs) and when they are not.

Estimates of the *increase* in client change variables that can be ascribed to rehabilitation are almost always based on the assumption that the client's performance at the time of referral (or perhaps some prior longer period) would continue indefinitely in the absence of rehabilitation. Although this may be a reasonably correct assumption for most nonvocational client change variables (such as an increase in physical dexterity), it is unquestionably misleading as a measure of vocational change.

On the one hand, even in the absence of rehabilitation, many clients without earnings would locate work so that "before and after" measures would overstate benefits. And, also, almost all clients with significant earnings at referral seek services in order to forestall job loss so that "before and after" measures would understate the benefits that should be ascribed to rehabilitation. Nor can "before and after" measures be used as a measure of *relative* vocational improvement since the validity of these data differs by demographic groupings. For example, earnings at acceptance are clearly of no value for predicting future earnings in the case of teenage referrals from school systems. This variation by demographic grouping reduces the usefulness of before and after studies of earnings for weighting purposes.

A third problem is that information for weighting purposes is likely to be collected by the rehabilitation counselor, which raises the specter of self-serving, perhaps wishful answers.

A fourth problem is that relatively homogeneous demographic groupings must be defined for each of the variables entering into a weighted case closure system, i.e., groups where the expected costs of services or the probability of success or the expected use of counselor time, or the expected outcome are roughly the same for each person. It is probable that the homogeneous demographic groupings will differ for each of these variables. As indicated above, the norms for these groupings would be the basis on which weights are calculated.

Potentially, the number of demographic groupings that may be involved is large. To begin with, many demographic variables must be considered—age, sex, race, education, marital status, type of disability, existence of secondary disabilities, status on income maintenance programs, etc. In addition, they are often interactive, i.e., their combined effect cannot be predicted from their independent effects. For example, a limited education will not seriously handicap otherwise physically and mentally normal persons and many disabled persons with good educational backgrounds have little problem obtaining employment. But the combination of limited education and a handicap will often be vocationally disastrous.

If there is interaction, then we must consider groups defined by combinations of demographic variables. There are literally thousands of possible interactive combinations. For example, suppose we consider six age categories, four educational categories, two for sex, two for race, three for marital status, ten for disability type, two for income maintenance program status, and two for secondary disability status. The number of combinations is over 11,000. Finer breakdowns or the addition of new variables would increase this number rapidly.

Of course, no system with this many groupings would be viable. There are two ways to simplify the procedure. Statistically, the differences between many groups will be sufficiently small so that they need not be separated. For example, we may combine all single limb amputations rather than consider arm and leg amputations separately. In addition, in many cases, hopefully most, the interaction factor will be sufficiently small so that it can be omitted. For example, marital status is usually found to affect rehabilitation outcome. However, if the effect is roughly the same over all age, diagnostic and other relevant variables, then this variable can be handled by simply altering the weight attached to closures by a uniform factor over all demographic groupings of a given marital status (eliminating two-thirds of the potential demographic groupings).

Despite all efforts that may be made to identify relatively homogeneous groupings of rehabilitants, there will remain important differences among rehabilitants within these groups for which a weighted case closure system cannot take account. Among the more important of these differences is motivation. Despite the importance of this variable, methods of measuring motivation are usually time-consuming and of dubious validity.

Combining Variables

Even if some solution to the problem of measurement is found, there remains the difficult and arbitrary task of combining the information that has been collected into a unique weight for each closure. Suppose that for a rehabilitant:

S=probability of success of persons in the demographic group into which the rehabilitant falls.

T=time expended by counselor on rehabilitant.

C=case service costs (or social costs excluding counseling).

D=client change.

W=weight.

Then one possible weighting system would be:

$$W=\frac{1}{S}\times\frac{T_s T_s}{T_t T}\times\frac{C_s}{C}\times\frac{D}{D_s}$$

The subscripts "s" and "t" refer to the average value for the demographic group and the average for all rehabilitants respectively.

This formidable looking equation merely expresses our earlier thoughts symbolically. 1/S increases the weights, W, as the probability of rehabilitation success decreases; T_s/T_t increases W if average counselor time for the group exceeds the average for all rehabilitants; T_s/T and C_s/C causes W to decrease if the counselor time or case service expenditures for the client exceeds the average for the group; and D/D_s causes W to increase if the client change exceeds the average for the demographic group. Obviously, the converse of each of the above statements holds.

The above equation could be simplified by deleting the T_s/T term (eliminating the need for counselors to record man-hours spent with clients). Or services to the severely disabled could be emphasized by substituting

$$(1/S)^2 \text{ for } 1/S \ (1/S>1).$$

Many other variations could be presented, each with its own rationale. And new forms of equations could be developed, each with numerous variations.

The point is that there are numerous ways in which weights could be computed, none of which is obviously the "best" way. Decision makers will have to select, from the various alternatives, that approach which is most reflective of the relative importance of the different program goals.

Another problem in computing weights is the difficulty of combining client change variables. How does one combine vocational benefits with nonvocational benefits

when the latter are not measured in monetary terms? Or how does one place a meaningful value on homemaking services for weighting purposes?

Uses and Problems

A weighted case closure system will improve performance comparisons among rehabilitation counselors, State programs, and comparisons of the program over time; it will reduce the incentive for "creaming" since counselors will probably receive extra credit for accepting difficult or risky cases; it will encourage the use of rehabilitation resources for high priority groups such as drug users, alcoholics, etc.; it will place emphasis on maximum improvement in the client; and it will promote greater efficiency in the use of rehabilitation resources.

One fact is clear. Manipulating the way in which variables influence weights affects the motivation of counselors to accept or reject difficult clients and the effort they are willing to expend on them. A weighted case closure system, therefore, is a management tool, and its importance as a management tool probably ranks ahead of its importance as a means of comparing the performance of States or counselors.

A weighted case closure system will not be without problems. As long as some relevant variables are not taken into account, there always remains a strong possibility of creaming, particularly since there are likely to be wide variations of motivation and severity of disability within demographic groups. It should be noted that creaming is not necessarily bad if it merely means that counselors select applicants that have the more promising prospects. The practice becomes questionable only if clients are selected that would have adjusted vocationally without rehabilitation.

A more serious problem is that a weighted system could become cumbersome and complicated as elaborate and time consuming questionnaires are devised to measure a wide number of client change, counselor effort, and resource use variables. This clearly would be regarded by State rehabilitation agencies as an unacceptable diversion from their assigned task of rehabilitating people.

Ultimately, such a system undoubtedly will be a compromise between the necessity of simplicity and ease of administration and the desirability of comprehensiveness.

Most weighting systems proposed to date have, in fact, been based on a single variable, rather than an amalgamation of the four factors described above. Weighting systems devised by Sermon,[1] Miller and Barillas,[2] and Wallis and Bozarth,[3] were based on the percentage of referrals successfully rehabilitated in a demographic group (our risk factor). Goff[4] and Miller[5] developed weighting systems based on differing time in process among different demographic groupings of rehabilitants (which could serve as a proxy for our risk and effort factors). Harper[6] and Silver[7] utilized counselor opinions as to the relative difficulty of rehabilitating different demographic groups as a basis for weighting (which could also serve as a proxy for the risk and effort factors).

The next article in this journal represents the first effort to develop weights on the basis of one of the benefits of rehabilitation—earnings at closure.

Succeeding efforts will undoubtedly contrast the differences in these truncated systems and will begin to develop systems using a combination of the risk, effort, resource use, and client change factors.

References

(1) Sermon, Duane, *The difficulty Index—An Expanded Measure of Counselor Performance.* Minnesota Division of Vocational Rehabilitation, Research Monograph No. 1, Mar. 1972.

(2) Miller, Leonard A. and Barillas, Mario G. "Using Weighted 26-Closures as a More Adequate Measure of Counselor and Agency Effort in Rehabilitation" *Rehabilitation Counseling Bulletin,* Dec. 1967.

(3) Wallis, Janice H. and Bozarth, Jerold D. "The Development and Evaluation of Weighted DVR Closures," *Rehabilitation Research and Practice Review.* Summer 1971.

(4) Goff, Clinton. *An Objective Index for Measuring the Vocational Rehabilitation Counselor's Caseload Difficulty.* Unpublished Ph.D. thesis, The University of Oklahoma, 1969, mimeographed.

(5) Miller, Clinton Millage. *An Index of Counselor Effectiveness.* Unpublished Report, no date.

(6) Harper, Ronald B. *The Design and Application of a Scale for Assigning Differential Weights to Rehabilitation Clients in State-Federal Rehabilitation Agencies.* Unpublished Ph.D. Thesis, University of Southern California, Feb. 1972.

(7) Silver, Diana. *Weighted Case Closures for More Appropriate Evaluation of Vocational Rehabilitation Counselors.* Unpublished Ph.D. thesis, The University of Texas, Jan. 1967.

Quotes

Perhaps the most damaging force to the counselor's self-concept, and increasingly to the image of the entire vocational rehabilitation program, is the so-called "numbers game." The pressure, whether expressed or implied, to demonstrate substantial increases in the number of people rehabilitated . . . results in a perversion of both program objectives and counselor job satisfaction (National Citizens Advisory Committee on Vocational Rehabilitation, 1968, p. 30).

The Committee will ask not solely how many persons were processed, served and rehabilitated, but also how difficult was the task and how much change was effected in each individual client (The House Committee on Education and Labor Report #92–928, p. 3).

Actuarial System For Weighting Case Closures

John H. Noble, Jr., Ph. D.

The present system for assigning credits to cases closed in the State-Federal Vocational Rehabilitation Program distinguishes between those which result in gainful employment or its equivalent and those which fail. Closure in status 26 [1]—"rehabilitated"—combines work in the competitive job market, employment in sheltered workshops, unpaid work by homemakers, and employment in a family business. Statistically, this confounds dissimilar phenomena and treats them as equivalent in a single index of "success." In like fashion, status 26 closures do not give indication of the relative difficulty involved in achieving the rehabilitation goal for specific cases. Degree of goal attainment is not described on a continuous scale.

Thus a quadriplegic who secures employment at $15 per hour, after receiving hundreds of hours of personal care, counseling, and training as a computer programer, is equated with the hernia patient returning to work as a manual laborer at the minimum wage. The one case is obviously not equivalent to the other in terms of difficulty, challenge to the professionals involved, resources expended by VR and other agencies, or contribution of wages earned to the Gross National Product (GNP). What is needed to correct the inadequacies of the present method of measuring "success" is a system for weighting closures so that all cases can be compared with one another on a single dimension which reflects degree of rehabilitation goal attainment.

Proposed System

The proposed weighting system uses the Federal minimum wage as the standard against which to judge achievements by the State-Federal Vocational Rehabilitation Program. A case is weighted positively to the extent that it achieves or exceeds the standard. Conversely, a case receives negative weight to the degree that it fails to achieve the standard. The national experience of the VR program is the actuarial basis for estimating the probabilities of "success" and "failure."

In technical terms, let "p" stand for the probability that case "y" is less than or equal to some hourly wage "m." Then "q" or "1—p" stands for the probability that case "y" exceeds "m." Let the current Federal minimum wage, $1.60 per hour, be the point on the hourly wage scale which separates positive values (wages in excess of the minimum) from negative values (wages below the minimum).

Using R–300 data for the most recent fiscal year, convert weekly earnings to hourly wage equivalents and calculate the cumulative frequency distributions for each disability class by age, by sex, by race, by education. The resultant cumulative frequency polygons all assume S-shaped curves which represent the probability "p" that any case "y" in a class was less than or equal to any hourly wage "m." "q," the inverse of "p" represents, as previously stated, the probability that case "y" exceeded "m."

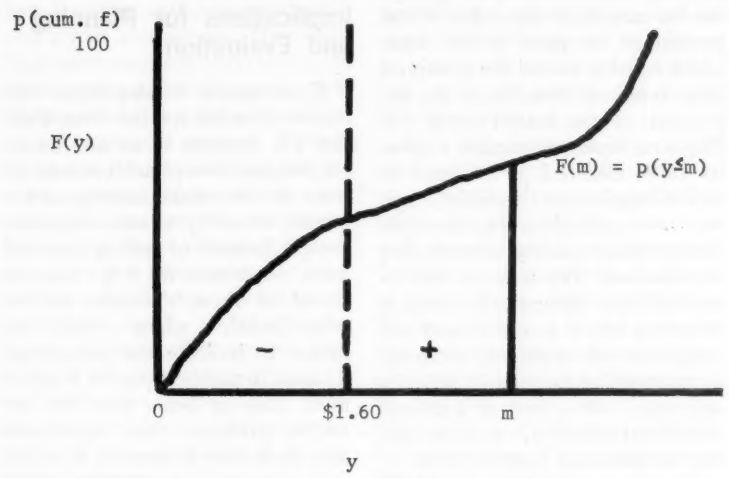
Hourly wages at closure lying above the minimum wage standard are weighted positively by reference to "p," the probability that case "y" was less than or equal to "m." Wages at closure falling below the standard receive negative weights by reference to "q," the probability that case "y" exceeded "m." By using "p" as the basis for assigning positive values and "q" for negative values, symmetry and commensurability are preserved. Cases assume appropriately greater or lesser values as they approach or recede from the minimum wage standard from the positive or negative side (Fig. 1). Theoretically, cases can receive weights ranging from 0 to ±100. The range may be narrower in practice.

What population base should be used to calculate weights? Several options come to mind: (1) Status 26 closures only; (2) Status 26, 28, and 30 closures [2] combined; and (3) All cases referred and/or applying for services.

In actuality, using status 26 closures as the basis for calculating weights is the only meaningful option. There are no earnings attributable to program intervention with respect to status 28 and 30 closures, nor with respect to cases closed at the referral and/or application phase. Adding zero-wage cases to the calculation of weights would re-

Dr. Noble is Director, Research and Evaluation Staff, Office of Planning and Policy Development, RSA. *The author thanks Dr. Saad Nagi, Mershon Professor of Sociology and Public Policy, Ohio State University, and Mr. Rocco D'Amico, Program Analyst, Office of the Assistant Secretary for Planning and Evaluation, HEW, for their comments on an earlier draft of this paper.*

Figure 1
Theoretical Cumulative
Distribution Curve Representing
Wages at Closure



duce the range of possible values by a factor equal to the percentage of cases without earnings.

To make the system applicable to homemakers and unpaid work in family businesses, we must place a monetary value on such work. Since economists have not reached any agreement on what an hour of a homemaker's labor is worth, we can assign the hourly wage equivalent for the average year-round earnings of a full-time female worker, further classified by age and race, as reported by the Bureau of the Census.[3] It is a moot point whether homemakers work 5, 6, or 7 days, and whether their work day is 8, 12, or 16 hours long. We are not interested here in calculating overtime wages for rehabilitated homemakers! The value of unpaid work in a family business can be approximated in similar fashion. Greater precision can be obtained in the future by having State VR agencies report the prevailing local hourly wage rate for the type of job held by the unpaid worker, using the *Dictionary of Occupational Titles* three-digit classification.

In summary, the proposed weighting system gives credit for closures which equal or exceed the Federal minimum wage in accordance with actuarial norms established by the aggregate of State VR agency practice. It applies the same norms to subtract credit for closures falling below the minimum wage. All cases failing to achieve an employment outcome or its equivalent are classified as "unsuccessfully served."

Discussion

This system has several advantages. From an administrative point of view, it uses existing R–300 reporting conventions; requires minimal reorientation of State agency personnel, and will not cost very much more to calculate earnings distributions and weights than is now expended on R–300 data processing. By using the Federal minimum wage, there is built-in provision for revision of this standard by law as the economy changes. The Federal minimum wage is itself a conservative standard—amounting to only $64 for a 40-hour week, or $3,328 per year gross. One could choose, after all, more stringent standards of program "success" or productivity upon which to base calculations of probabilities and weights, e.g., the family income to poverty level ratio.

Technically, the system has the virtue of simplicity because its underlying mathematical model requires no assumptions about the shape of earnings distributions or metric type. It is also flexible, allowing distributions and probabilities to be calculated for the several disability-sociodemographic groups, defined finely or crudely. The output is easily interpreted by the layman—virtually everybody who plays poker understands the relative value of suits based upon the odds for or against their occurrence.

Depending upon whose "ox is gored," the following disadvantages will be noted. First, the proposed system assigns negative weights to cases now getting counted as "1," yet which fall below the minimum wage. Second, it applies the Federal minimum wage standard as the measure of VR program productivity to all States, including those which do not accept it. Third, the system does not explicitly take into account nonwage benefits to clients.

In balancing advantages against disadvantages, the proposed system would be an improvement over the present "equal" weighting system because it would offer incentives to State VR agency personnel to work more intensively and extensively with the more severely handicapped in order to place them in jobs paying at least the Federal minimum wage. To the extent that the amount of earned income is a proxy for the degree of independence enjoyed by clients after closure, weighting closures in terms of wages can represent some of the noneconomic benefits imputed to the State-Federal Vocational Rehabilitation Program. The system will certainly expose the dependency of a person declared rehabilitated as a sheltered workshop employee being paid $.50 per hour. As such, it is likely to place pressure upon sheltered workshops to achieve economies of scale in their operations so that they might become able to pay the mini-

mum wage, or force recognition that workshop wages must somehow be subsidized if these wages are meant to provide—beyond therapeutic value—significant economic support.

A compromise system which assigns a weight of "1" to closures falling below the minimum wage is possible, if change to a system of "negative" weights is considered too abrupt a break with traditional practice, or the minimum wage too difficult a placement goal for most counselors because of general discrimination against the handicapped. Closures resulting in earnings at or exceeding the minimum wage would still receive additional positive weights and continue to act as an incentive to serve the more severely handicapped.

This proposed system can accommodate States which do not accept the Federal minimum wage by computing actuarial tables of hourly earnings at closure for the several disability-sociodemographic groups for each of the major economic regions of the country. If job market conditions and prevailing wage rates are factors influencing the probability of closure into minimum wage or better jobs, the actuarial tables will reflect this fact and, in so doing, automatically assign greater weight to such closures in disadvantaged areas.

Finally, it is important to note that the proposed system automatically discounts the value of "gimmick" closures, e.g., buying eyeglasses for college graduates about to enter the job market. The greater the likelihood of a guaranteed successful closure, the lesser the weight. While publication of the weights applying to each year's closures is anticipated, the weights of previous years are only a guide, not a guarantee that the current year's practice will yield the same weights.

Severity of Vocational Disability

The actuarial principles underlying the weighting system being proposed can be applied to define and measure the severity of *vocational* disability. The array of disability-sociodemographic groups can be ranked in the order of the percentage of cases within each which equal or exceed the minimum wage standard. Based upon the experience of the State-Federal VR Program, these percentages express for cases, classified by reference to type of impairment (disability), age, sex, race, and education, the odds against their equaling or exceeding the standard. The scale of odds or probabilities, theoretically ranging from 0 to 100, in turn represents the magnitude of vocational disability as expressed by the relative difficulty associated with achieving a defined vocational objective; viz., a job paying the minimum wage or better.

The Congress by statute, or HEW by Federal regulation, could easily apply this actuarial concept and measure of vocational disability to establish an unambiguous legal definition of severity. The legal definition of "severe" vocational disability could be as stringent as one-in-ten odds against placement in a minimum wage or better job, or as lax as even odds (one-in-two).[4]

By taking this approach to the legal definition of "severe" disability, Congress and HEW would be giving recognition to the distinction between *impairment,* the physiological or anatomical loss of capacity to function due to illness or trauma, and *disability,* which reflects, in addition to impairment, both the objective and discriminatory contributions of age, sex, race, and education to a person's functional limitations in the vocational sphere. Not every impairment creates disability, nor do identical types of impairment impose similar degrees of vocational disability.[5] In the search for a workable legal definition of "severe" disability for use in the context of vocational rehabilitation legislation, actuarial methods seem to offer the most feasible solution to the problem of weighing the relative contributions of impairment and sociodemographic factors to vocational disability.

Implications for Planning and Evaluation

If the system is adopted, it will become possible for the State-Federal VR Program to set and monitor progress toward achievement of more precise rehabilitation goals for specific disability-sociodemographic groups. Instead of stating national goals in terms of "'x' number served, of whom 'y' number will be rehabilitated," plans could be drawn to indicate the percentage increase in numbers placed in minimum wage or better jobs. For example, previous years' experience may show that 95 percent of black, male paraplegics between 18 and 25 years of age with a high school or better education are placed in jobs paying less than the minimum wage. This record, based upon significantly higher productivity in a few places, might be considered unacceptable for the program as a whole. In consequence, the national 5-year plan could set for itself the goal of improving wages for this group by 5 percent or some other achievable rate per year. In like fashion, the entire array of disability-sociodemographic groups can be covered.

Once the goal of improving wages is translated into the resources necessary to accomplish it, it may become evident that the traditional quantitative increase in numbers served of roughly 10 percent per year is incompatible with simultaneous achievement of higher wages. Better jobs and increased worker productivity are the means to this end. If the loss of sheer numbers is considered a suitable tradeoff against improvements in jobs and worker productivity, the State-Federal VR Program will then take a very different stance in monitoring progress and evaluating the outcomes of the rehabilitation process.

There will be less emphasis upon building up the "stock" of referrals and more emphasis upon the "flow" of clients through appropriate services, training, and job-conditioning and tryout experiences. There will be greater emphasis upon economic development activities, creating job opportunities for specific disability-sociodemographic groups. Follow-along and followup services will become critical elements in the campaign to convince employers that hiring the handicapped does pay off by providing stable and productive employees. Incomplete preparation and/or too hasty withdrawal of supportive services jeopardizes not only the likelihood of success for the person placed in a job, but may also sour the employer against giving another handicapped person a chance.

The proposed system cannot by itself restructure the goal orientation of the State-Federal VR Program. It can only provide an actuarial basis for giving more credit for placement of clients in jobs affording greater payoff in economic benefits to the client and/or in reducing the burden of dependency upon society. It can help pinpoint program achievements and deficiencies in relation to specific disability-sociodemographic groups and allow, thereby, formulation of precise plans for improvement.

If adopted, the system would act as a disincentive against "doing it by the numbers." It would lay the burden of proof on VR agencies and counselors to explain why closure in employment paying less than the Federal minimum wage was the best that could be expected under the circumstances. The system, therefore, should not be adopted without introducing concomitant changes in the Federal and State policies and practices which tend to influence in the direction of maximized numerical output the setting of basic program goals, case management and supervisory practice, recruitment and promotion of personnel, and relationships with other agencies. To adopt the system without making these adjustments would strain VR agencies and counselors unconscionably by creating a demand for maximized performance in relation to incompatible objectives—"numbers" and jobs paying at least the minimum wage.

Both the Congress and HEW have supported in public testimony the concept of an accountability system which provides incentives and recognition to agencies and counselors who accept the challenge of serving more difficult cases.[6] In the long run, it is hoped that the new accountability system incorporating weighted case closures can be expanded to include a peer review process involving counselors and supervisors. The resultant system would then become the principal mechanism within the VR program for training and upgrading staff capabilities for decision making and for increasing general ability to manage well the scarce resources of counselor time and case service funds.

Notes and References

(1) Status 26—case closed, rehabilitated.

(2) Status 28—case closed, not rehabilitated, but client received some services. Status 30—case closed, not rehabilitated, but client received no services.

(3) U.S. Department of Commerce, Bureau of the Census, *Income in 1970 of Families and Persons in the United States.* Current Population Reports, P–60/80. Government Printing Office, October 4, 1971.

(4) In fiscal year 1970, 43 percent of all cases closed in statuses 26, 28, and 30 were working in jobs worth at least the minimum wage. In contrast to weighting cases by reference to the earnings of status 26 closures, all cases seriously considered as candidates for VR services, even though they are eventually closed in statuses 28 and 30 without earnings attributable to the VR program, are the proper population to use in computing the magnitude (severity) of vocational disability. To limit computations to status 26 closures only would distort the true picture of vocational risk attached to membership in specific disability-sociodemographic groups; e.g., the black, male paraplegic with less than a high school education, regardless of age. If sufficient information is collected on cases closed in the referral and applicant stages of processing (00–02 statuses), the more severely handicapped persons now denied services at the outset because of "nonfeasibility" can be included in computation of vocational disability to give an even more accurate estimate of risk.

(5) Nagi, Saad Z. *Disability and Rehabilitation: Legal, Clinical, and Self-Concepts and Measurement.* Columbus: Ohio State University Press, 1969.

(6) Hearings on H.R. 8395 before the Subcommittee on the Handicapped of the Committee on Labor and Public Welfare, U.S. Senate, 92d Congress, 2d Session, May 15, 18, and 23, 1972, Part 1, p. 135.

NEW PUBLICATIONS

(*continued from page 19*)

show how new technologies, such as remote controlled physicologic monitoring, early life-support care, and use of paraprofessionals, can reduce the morbidity and mortality associated with accidents and sudden illnesses. Several articles pinpoint the gap between current emergency medical practices and standards formulated by experts in the field, while making recommendations to hospital trustees, administrators, medical staff, and nurses about their legal responsibilities.

Major Modalities in the Treatment of Drug Abuse. Leon Brill and Louis Lieberman, editors. 313 pages. $12.95. The Yearbook of Drug Abuse. Leon Brill and Ernest Harms, editors. 386 pages. $19.95. Methadone: Experiences and Issues. Carl D. Chambers and Leon Brill, editors. 411 pages. $19.95. Behavorial Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025.

These three books should furnish the basis for a good library on drug abuse. The professional worker in vocational rehabilitation, however, probably would want to add to the library more on what one of the volumes calls "deaddiction," i.e. vocational rehabilitation.

In ***Major Modalities*** the editors bring together contributors with

(*continued on page 40*)

What Does Rehabilitation *Really* Need?

Isadore Salkind

An article by Simon Olshansky, "Six Scandals in Vocational Rehabilitation" (*Rehabilitation Record,* January–February 1973), raised some basic questions about problems in rehabilitation. There were some very thoughtful responses to his article, but I feel that neither the "scandals" nor the rejoinders provide an adequate basis for dealing with the problems cited. They were: lack of adequate supervision over counselors, their exclusion from policymaking, the exclusion of the disabled from program planning involving their lives, the neglect of long term clients who cannot compete in the open labor market, the overselling of counseling in solving the rehabilitation problems of the clients, and the "closure mystique" which optimizes success with numbers and minimizes humane treatment at severe levels of disability.

Olshansky offers inadequate analysis in my view since he is criticizing symptoms rather than diagnosing the disease. The rejoinders, though intelligent, suffer from a lack of broad social context. Without presuming that I can "see the whole elephant" while my colleagues see only a particular part, I'd like to offer a critique of the "scandals" and a possible solution.

To begin with, the counselor finds massive client problems for which there are no easy answers. If we take a look at a composite of our clientele, we find a person who essentially is unskilled, undereducated, poor, disabled, and mirrored in a negative self-image. What can the counselor offer by way of choices in the existing labor market? We find many clients whose basic response to these difficulties is the development of a life-style which is self-defeating even when opportunities do exist. I don't want to indicate that these people can't be helped or that they can't work. In fact, if the government decided that it needed to create 4 to 5 million jobs in the society, a very substantial portion of our caseloads would easily disappear. But that option currently doesn't exist. And, as a matter of fact, we deal with such a small fraction of the people who want and need help that our rehabilitation effort must be seen as an exercise in tokenism.

Federal reports indicate that from 2 to 5 million people are in need of rehabilitation services, with the backlog increasing all the time. With this kind of pressure on available rehabilitation resources, only a selected few can be dealt with properly. Counselors know the realities of the job market, and they are painfully aware of their clients' problems. Giving them more or closer supervision wouldn't change these factors. Likewise, though counselors would appreciate sharing in the decisionmaking process, they would be among the first to recognize that this couldn't do much for them or their clients unless other things changed drastically.

Many counselors feel that they, along with their clients, are victims of the system. Having a larger role in the decisionmaking process within the existing structure might be even more frustrating!

For those clients who need rehabilitation services, the intention to include them in the planning would be great. Certainly, clients really participating in their own rehabilitation planning would become aware of the limited choices available to them. If we were more open about this, some of the clients might get the idea that activist kinds of solutions are needed. This would indeed be a real contribution if it helped the larger society to see how poorly it sets its priorities and distributes its resources.

Here again, with respect to the terminal needs of clients who can't compete in the labor market, most terminal facilities are a disgrace. But the failure has to be very broadly shared. Those who are powerful in the society determine what our attitudes toward the seriously handicapped shall be, and, ultimately, what we will spend on their behalf. As leaders in the field, we haven't articulated the needs of the terminal populations. In fact, we have studiously avoided becoming their advocates and have sought to shape our major efforts around the transi-

Mr. Salkind is Director, Rehabilitation Workshop Administration, University of San Francisco.

tional client. That's where the glamour and the dollars have been. Even with stronger advocacy, this problem would be profound because it is so fundamentally related to the way in which the society permits nonhuman value systems to dominate and control budgets and priorities.

Given the harsh realities which counselors have to face, it is no great surprise that they are shocked by the gap between what they got in the rehabilitation counseling training programs and what they face daily. They discover that the talk therapies, which lie at the core of most counseling techniques, don't help much if you can't change some of the very difficult life situations of the clients.

It isn't that counseling is oversold, rather than it is a thin, nondimensional approach to the problems people have. It is also true that our medical origins as a rehabilitation movement have not helped us to see the interrelationships between disability, poverty, and lack of opportunity. It's much easier to look for clinical illness and label it. Our strong heritage of Freudian psychoanalysis hasn't helped us to take into account the overwhelming societal realities. Perhaps this is why we hardly notice, when riding over a freeway, the giant signs which say "Don't Litter." These signs invariably are over those parts of the city which are dead or dying and strewn with the decay of ghetto housing and urban ruin.

Does all this seem to be saying that the sad state of affairs is really the fault of society? In one sense, it does. At least one way of saying it would be to recognize that a rehabilitation movement can't be significantly better than the society from which it springs. Yet, we as professionals are not absolved—we have refused to become client advocates, while admitting that clients don't have their own lobbies or organizations. To become client advocates would require rehabilitation workers to become political at the grassroots level, to get involved with State legislators so as to influence the amount going into matching funds for Federal moneys, etc.

Our failure to become even faintly political and the reasons for this are too numerous to detail here. But its price is a high one, paid mainly by our clients, with some of our own frustrations thrown in. Of course, the traditional rationale has been that if we enter the political arena, we would somehow be less effective as professionals. For most of us it is also true that becoming political has the implication of becoming personally corrupt.

As a result of our unwillingness to act, we and our clients become victims of destructive political decisions. For example, the military budget for next year happens to include an amount of $590 million which is supposed to buy seven destroyers, if there are no cost overruns. This happens to be roughly the amount of case services money available for the entire country for rehabilitation in fiscal year 1972–73. While this might be seen in some quarters as two entities entirely unrelated to each other, don't we in rehabilitation have some obligations to struggle for more intelligent national priorities? Or do we go on pretending that the cost of seven destroyers is none of rehabilitation's damned business?

If rehabilitation professionals were to become seriously political, what could they do? First, they would admit that the problems of rehabilitation can't be solved in a vacuum and that they are part and parcel of the major problems of the society. They would then say, very straightforwardly: "Much of the problem of our clients rests, not with their inability to work, but with the unavailability of jobs." Therefore, let's insist upon the large scale creation of more jobs. How can we create a *million* jobs in the next 5 years?

There already exists a partial answer. Within 5 years the current workshop movement, which now at any given time may have 100,000 people, could expand to accommodate 1 million workers. Let's assume that these workers would be paid a minimum of $2 per hour. If every worker worked 2,000 hours per year, this would cost $4 billion. But if these jobs were created in rehabilitation workshops, at least 40 percent of this cost would be generated by the workshops, thus reducing the cost from 4 billion to 2.4 billion per year (far less than the average annual costs of defense overruns).

This is quite a projected leap from where workshops are right now, but not far from where they could be. With a subsidized minimum wage, a vast upgrading of shop services, equipment, and personnel would be possible. We can reasonably assume a much higher rate of placement occurring as larger numbers of people begin to see themselves as employable and able to compete in the labor market. Just think what it would mean to counselors and to the entire vocational rehabilitation structure if they had a ready employment resource to which they could quickly refer clients for a minimum wage. Nor would such employment in workshops have to be simple assembly. There could be a wide array of work experiences possible, from simple to complex.

The possibility of transforming a disabled, disadvantaged population into a productive one can only be realized through extensive job creation. Undeveloped as it now is, the rehabilitation workshop has within it the possibility of providing some important solutions to such a population.

The implications for the welfare problem are enormous. We really cannot project how much this might reduce the cost of welfare, because the overwhelming majority of people on welfare just aren't employable. But it is reasonable to assume that a major portion of the employable people now on welfare would much prefer to be productive in a

rehabilitation workshop than continue to experience the degradation of involuntary employment.

It might be argued from an economic point of view that jobs created in workshops would merely decrease employment in private industry. But this could only be true if workshops just took in subcontracts previously performed by the companies on their own premises. Even if this happened, the people being displaced would be more easily absorbed into the labor market than those given employment in the workshop. It is probable, on the basis of current productivity ratios, that for every worker displaced from private industry, two would be absorbed in workshops, so that there would be a relative net gain in employment of major proportion.

The essential point, however, is that workshops do not have to confine themselves to subcontracts involving any displacement of existing employment. They can produce goods and services of a wide range which are not now being done. The entire field of reclamation and salvage, which has been confined to clothing and household goods, could be expanded to all goods, from old houses to public parks. If one seriously thinks of what is needed to rebuild the decaying center of almost every American city, the employment potential is enormous. As far back as 1960, the National Planning Association's Center for Priority Analysis indicated from its study that to achieve the 16 goals outlined by President Eisenhower's commission would require an employed labor force of more than 100 million—some 10 million more than are expected to be in the civilian labor force in 1975.[1]

The point about all this is that there are at least partial solutions available, but they are political and economic in nature. They can only come about if rehabilitation professionals are willing to make and articulate the connection between the cost of destroyers and the cost of rehabilitation. If we can't make these connections, we fail our clients badly and don't deserve to be called professionals. For those who say to us "Do you really expect to change the world?" the only real answer would be, "Yes, we've got to try to change whatever it is that prevents us from doing what we're supposed to do for and with our clients."

Reference

(1) Lecht, Leonard, A. *Manpower Needs for National Goals in the 1970's.* Frederick A. Prager, New York: 1969. p. 183.

NEW PUBLICATIONS

(*continued from page 37*)

decades of treatment and research experiences gained within chemical and nonchemical programs, with narcotic and nonnarcotic abusers, with voluntary and nonvoluntary patients, with detoxification and maintenance management, and with authoritarian and permissive techniques.

The past two decades have seen many attempts to stem the tide of drug abuse in the U.S. The reasons treatment and prevention efforts have not been more successful is a first order of magnitude question for anyone determined to solve this problem. *Yearbook* offers a forum for a wide-ranging presentation of the problems encountered, and some of the possible answers that have emerged. The 17 papers include: descriptions of the drug scenes in California, Puerto Rico, England, Chicago, New York, and Philadelphia; an overview of Federal programs; and special addiction reports on marijuana, heroin, and LSD.

The greater portion of *Methadone* is comprised of original papers summarizing the wide variations in approach and experience found in America and abroad, describing the sources of opposition, and culminating in a proposed rationale for the "multimodality" approach to methadone treatment, ranging from detoxification to a residential center/methadone maintenance facility.

Research Readings in Rehabilitation Counseling. Harold A. Moses and C. H. Patterson, editors. Stipes Publishing Company, 10–12 Chester St., Champaign, Ill. 61820. 429 pages. $8.60.

The editors have compiled these 50 readings in rehabilitation counseling as a demonstration of present research findings and utilization and as an encouragement for future research study and pragmatic implementation.

Among the general areas covered are: the importance and use of social research, the rehabilitation client, sheltered workshops and rehab centers, the counseling process, vocational evaluation, psychological and social aspects of disability, placement and employment. Each detailed rundown of project designs, procedures, results, and conclusions is then followed by a list of references.

Proceedings of the First All-India Workshop Conference on Stroke. Christian Medical College Hospital, Vellore–4, S. India. 204 pages.

This SRS–supported conference was held November 22–23, 1971.

The book brings together the conference papers related to stroke in the areas of vocational rehabilitation, epidemiology, youth, pathology and management, physio and occupational therapy, surgical rehabilitation, and electrodiagnosis.

Attitudes Toward the Retarded. A summary of studies to 1972. The President's Committee on Mental Retardation, Washington, D.C.

Fifteen studies on various aspects of people's attitudes toward retarded persons are presented here. The compilers admit that "this is not a complete listing of work in the field, and we would welcome suggestions for additions."

REHABILITATION RECORD

The weakest ink is better than the strongest memory

contents

SEPTEMBER–OCTOBER 1973

VOLUME 14, NUMBER 5

	Page
Productive Participation For Disturbed Youth Eliot D. Chapple	1
Family Rehabilitation In Process Louis Y. Nau	8
Retarded Attendants For The Handicapped Robert M. Urie and Donn Brolin	12
Psychotherapy: Bringing In The Client Hans H. Strupp and Anne L. Bloxom	15
Evaluation	
Evaluating Workshop Evaluations Simon Olshansky	22
A Critical Response Paul R. Hoffman and David W. Corthell	23
Case Weighting	
Weighting Case Closures: Concepts, Problems Ronald Conley	29
Actuarial System For Weighting Case Closures John H. Noble, Jr.	34
What Does Rehabilitation Really Need? Isadore Salkind	38

Features

New Publications, page 19 . . . Wheelchair Decor Contest Winners, page 20.

Published by

Rehabilitation Services Administration

Corbett Reedy
Acting Commissioner

Ron Bourgea, Editor
Room 3213, HEW South Building
Washington, D.C. 20201

Wilma Chinn
Editorial Assistant

Anna Krane
Editorial Assistant

Use of funds for printing the Rehabilitation Record was approved by the Director of the Bureau of the Budget, January 5. 1966. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Opinions expressed in this publication are those of their authors. They do not necessarily reflect the views of the Department and Agency.

At right is the International Symbol of Accessibility.

This publication is indexed in Hospital Literature Index and abstracted in Rehabilitation Literature and DHS Abstracts and Oklahoma State University Clearinghouse.

MAIL ORDER FORM

To: Government Printing Office
Washington, D.C. 20402

FOR USE OF SUPT. DOCS.	

Enclosed is $..... (check or money order) for a subscription to Rehabilitation Record (6 issues annually) for one ☐, two ☐, or three ☐ years. Annual subscription is $5.50, plus $1.50 for foreign mailing, single copies $1.

Name.....

Street address.....

City, State, and ZIP Code.....

UNITED STATES
GOVERNMENT PRINTING OFFICE
DIVISION OF PUBLIC DOCUMENTS
WASHINGTON, D.C. 20402

OFFICIAL BUSINESS

RREC UNIVM000U R 1
UNIV MICROFILMS
SERIALS DEPT
ANN ARBOR MI 48106

U.S.MAIL

REHABILITATION RECORD

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service

Rehabilitation Services Administration

Washington, D.C. 20201

Publication No. (SRS) 73-25900